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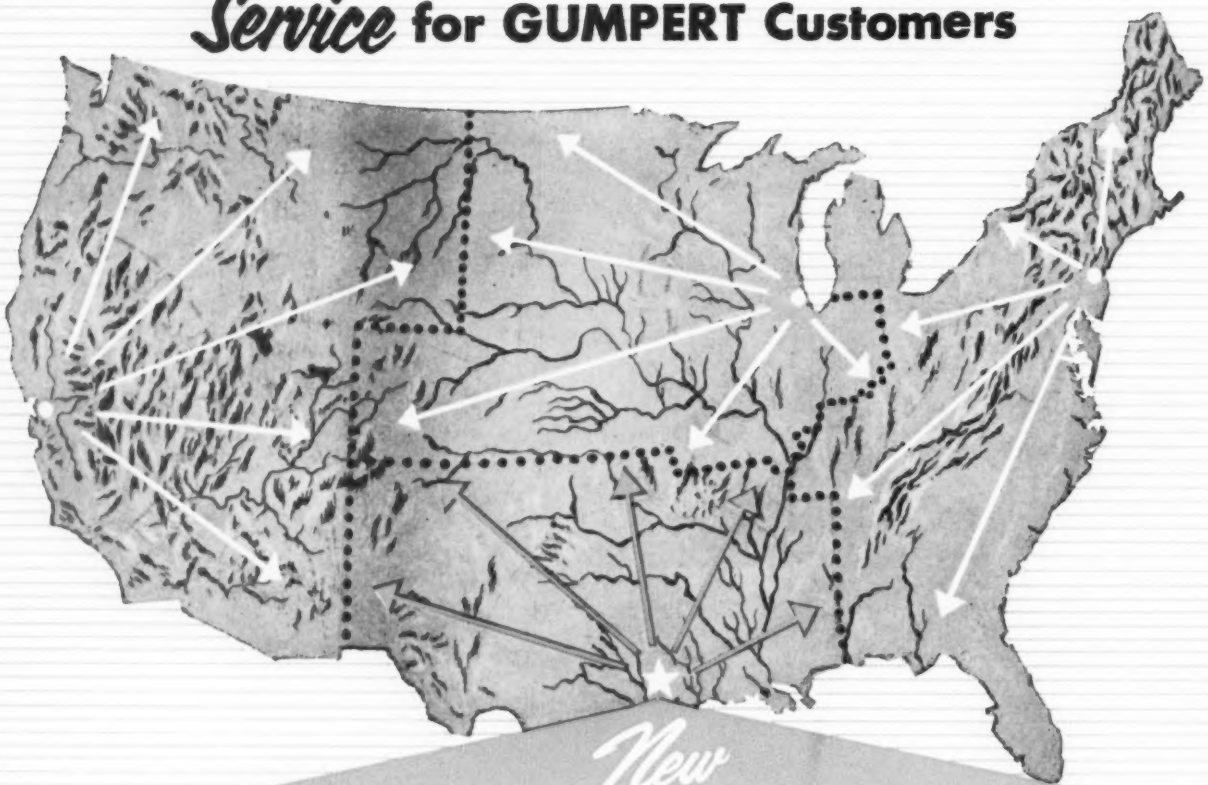

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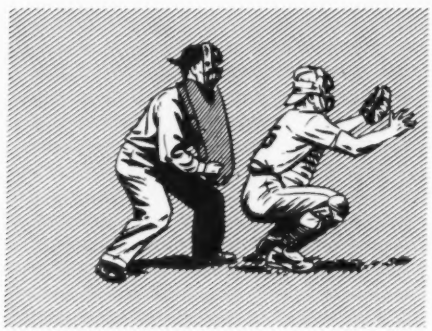

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The Modern Hospital

MAY 1954

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AMONG THE AUTHORS

Mary E. Williams

Mary E. Williams, who describes the interesting new hospital television program, "A Life in Your Hands," in the article on page 56, is director of publicity at Children's Hospital of the East Bay, Oakland, Calif. In this position, she handles hospital news and features and organizes a year-round program of fund raising activities sponsored by the hospital's 60 auxiliary branches. A graduate of the University of Illinois, Mrs. Williams was on the staff of the *Prairie Farmer* before moving to California, where she became woman's editor of the Alameda *Times-Star*. She left this position to enter the public relations field with her husband, Lawrence Williams, who writes and produces the television program, "A Life in Your Hands," with Richard Highsmith, administrator of Children's Hospital.

Donya Jacobi

Donya Jacobi is technician in charge of the blood bank at Chicago's South Shore Hospital. The bank, which Mrs. Jacobi planned and installed at the hospital, is described in the article and pictures on page 63. Mrs. Jacobi received her education in Vienna, Austria, and has studied at the University of Illinois and Northwestern University in Chicago. Before moving to South Shore Hospital four years ago, Mrs. Jacobi was technician in charge of the blood bank at Illinois Central Hospital, where she had served, previously, as technician in charge of the laboratories. The pictures of the South Shore blood bank appearing in this issue were made by Publix Pictorial Service, a photographic service operated by Leslie Jacobi, Mrs. Jacobi's husband.

Dr. Eugene D. Rosenfeld

Dr. Eugene D. Rosenfeld is director of the Long Island Jewish Hospital now nearing completion at Glen Oaks, Queens, N.Y. Dr. Rosenfeld took charge of the Long Island Jewish Hospital's building program when it was still in the planning stage, the various steps of which are described in his article beginning on page 67. Prior to his appointment to this position, Dr. Rosenfeld served for several years as assistant director of Montefiore Hospital in New York City. A graduate of the University of Colorado School of Medicine in 1943, Dr. Rosenfeld entered the army medical corps and served for two years in the Southwest Pacific, the Philippines and Japan, doing both tropical medicine and medical administration. Following his discharge from the army, he served an internship in pathology at Montefiore before switching to administration. The Long Island Jewish Hospital described in this issue is "Modern Hospital of the Month" for May.

Also appearing in The Modern Hospital this month are **Dr. Albert W. Snoke,** director of the Grace-New Haven Community Hospital at New Haven, Conn., and chairman of the council on professional practices of the American Hospital Association, and **Dr. Walter B. Martin** of Norfolk, Va., president-elect of the American Medical Association. In somewhat condensed form, the papers that Dr. Snoke and Dr. Martin presented at a symposium on hospital-physician relations conducted by the New York County Medical Society a month or so ago are reprinted here.

Reader Opinion

Are Prototype Studies "What Is"?

Mr. Lutes Asks Questions

Sirs:

There are a few comments I would like to make regarding the article, "Prototype Study: 200 Bed Hospital," in the January 1954 issue of The MODERN HOSPITAL. There are some questions I would like to have answered also.

To what fiscal period of operation does the information apply?

How many hospitals are represented in the survey? Were the hospitals that supplied the information located in one geographical area or were they scattered throughout the country?

Does the number of paid personnel include part-time and full-time employes?

Certain information contained in the article causes one to question its accuracy for present-day comparison. Room charges are considerably less than those found in any section of the U.S. as shown by the most recent study by the A.H.A. One also wonders how two employes in the medical record department can do justice to 6800 admissions. The average number of paid personnel (280-285) appears to be below the present average; the same is true of the per cent of pay roll to total operating expense.

It would seem to me that the total number of employe hours ought to be adopted as standard practice for comparative purposes on "employe" instead of the "number" of employes. This could then be listed under two headings — "paid" and "volunteers." Those listed under "paid" would include part-time and full-time workers.

Income per patient day averaged $18.50. It would appear that this high average would be very unusual when average room charges were listed as $12.50 for single room, $10 for two-person rooms and $8.25 for multi-person rooms. It is evident therefore that ancillary charges, per patient day, sufficient to increase income to an average of $18.50 would have to be much greater than the common experience.

J. Dewey Lutes
Superintendent
Woonsocket Hospital
Woonsocket, R. I.

Dr. Block Elucidates

Sirs:

The questions Mr. Lutes raises are pertinent and indicate careful consideration of the material presented in the prototype study patterns. However, the premise of approach to these studies was portrayed as the introduction to the first of the series, the 50 bed hospital. Since this did not appear as a preface to the 200 bed hospital study, I should like to restate it at this time.

"Although basic similarities in function do exist, each hospital is an entity in itself to a certain degree. As such it presents variations from any guide or composite because of local situations and local differences. Despite this, application of existing guides in plan-

ning over the years has established their usefulness, and their merits have become well recognized."

With regard to Mr. Lutes' specific questions, I should like to discuss them, one by one, as follows:

1. To what fiscal period of operation does the information apply?

The fiscal period is varied. For each specific item of information the latest available material was used at the time of its preparation. In certain studies as, for example, the 50 and 100 bed hospital prototypes, 1951 data as published in the American Hospital Association *Administrators Guide Issue,* June 1952, were used. These studies were prepared before the release of the latest *Administrators Guide Issue.* In addition, certain information was based on prior year data, since it was the only information available. In practically all instances latest national information was used at the time of preparation of material.

2. How many hospitals are represented in the survey?

The basic study pattern of the prototypes was a special analysis of hospitals listed in the June 1952 *Administrators Guide Issue.* To this were added refinements and adjustments based on additional special studies and available information. The hospital numbers included in the specific size groups were as follows:

	Bed Range	*No. of Hosp.*
25 Bed Hospital	20-29 beds	345
50 Bed Hospital	45-54 beds	294
100 Bed Hospital	95-104 beds	156
200 Bed Hospital	195-204 beds	97

3. Were the hospitals that supplied the information located in one geographical area or were they scattered throughout the country?

The hospital data represent information from all sections of the country. Where national data were adjusted or provided in greater detail, the information forming the basis of adjustments was derived from three or more different areas of the country.

4. Does the number of paid personnel include part-time and full-time employes?

Part-time and full-time employes were determined from existing information only for the 50 bed hospital prototype study. In all other size groups the number of personnel refers to full-time persons as reported in the American Hospital Association *Administrators Guide Issues.*

5. Room charges are considerably less than the most recent study of the American Hospital Association.

This is correct. The basic information concerning the prototype studies was developed around 1951 information. These studies were completed and submitted for publication prior to the release of the latest rate survey. In the development of these studies it was realized that new and more recent information would be forthcoming in many areas. For that reason it was emphasized in the introduction to the 25 bed hospital prototype, the last of the series. In this preface it was stated: "As new or refined information becomes available, the content may need revision."

6. Number of employes in the medical record department of the 200 bed hospital appears to be low.

This may be true in many instances. If the hospital is connected with or affiliated with an educational and research program or institution then the number indicated may be low. In other instances part-time personnel may be used, which are not reflected. In addition, since the figure is an average, it is possible to have more or less

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ATTENTION OF MR.

than the number indicated. The range for this hospital size group was from 1 to 5, with the average being 2. The number of medical record personnel will also be affected by the volume or activity of the outpatient department and emergency service.

7. The average number of paid personnel is low.

In accordance with the latest American Hospital Association figures the hospitals in the 100-249 bed size groups had about 183 full-time employes per 100 patients. In the 200 bed hospital with an average census of 154 patients this amounts to about 260 employes. The figures as presented in the 200 bed hospital prototype were from the 97 hospitals in the size range 195-204 beds and averaged 280-285. This does not appear to be low as an average for all hospitals of this size. It is true that local, state and regional differences do exist because of variations in hours of work and types of services provided.

8. The per cent pay roll of total operating expenses is low.

In accordance with the latest American Hospital Association figures, pay roll per patient day amounted to $11.09 and total expenses to $19.35 for nonprofit, general hospitals in the 100-249 bed size group. This amounts to pay roll accounting for 57.3 per cent of total expenses. For the 97 hospitals included in the study the figure amounted to 58 per cent and does not appear low.

9. Employe hours is a better index than number of employes.

This is a statement which I heartily endorse. However, until such information becomes generally available we shall have to be satisfied with numbers of employes as the information which is available.

10. Income per patient day of $18.50. When compared with room charges, the amount accounted for by ancillary services appears to be higher than expected.

This is true since room charge data are of a prior period to income data. It is unfortunate that the rate survey information adjustments could not have been made in time to appear in the published data.

In closing, I should like to reiterate that these studies are presentations of an average picture and as such it would be the rare and unexpected situation when it could be found to "fit like a glove" a particular situation. Its value lies in the fact that variations from it should be explainable in terms of the individual hospital operations and problems, and to the development of more recent information.

Louis Block, Dr. P.H.
Program Operations Branch

Division of Hospital Facilities
Public Health Service
Washington, D.C.

Most Questions Cleared, But —

Sirs:

Dr. Block's letter clears most of the questions that came to my mind as I read his article.

I wish to make the following observations:

1. It would seem to me that the studies would have carried greater weight if the fiscal period coverage had been explained with each published study. It might help the author as well as the reader if it was shown that some 1951 data were used in a 1954 release.

2. The use of only 97 hospitals scattered throughout nine geographical regions (representing all of the United States) might be considered insufficient for a prototype study.

3. I am of the positive opinion that there is an error in the number of employes in the medical record department. This does not mean that Dr. Block made the error.

4. I am fully aware that the prototype study represented an average picture and that it could not be expected to fit *any* hospital "like a glove," otherwise it might be given some title other than "Prototype."

J. Dewey Lutes

Medical Records Figure Corrected

Sirs:

A reconsideration of the staffing pattern for the 200 bed hospital, with special reference to the medical records department, required a tracing back to the original tabulations. It seems that Mr. Lutes' concern was justified inasmuch as instead of tabulating total personnel in this department, the number of medical record librarians was tabulated. Total figures show that personnel in medical records amounted to an average of between 4 and 5 instead of the 2 listed.

With regard to room charges, the data for 1953 would increase the figures shown to $14-$15 for single rooms, $12 for two-person rooms and $10 for multiperson rooms.

These changes are being noted for

distribution with reprints of the article.

Louis Block, Dr. P.H.

Depreciation Accounting

Sirs:

The views expressed by Lloyd Morey, Paul D. Shannon and Herbert E. Klarman regarding the question of depreciation in accounting for nonprofit hospital operations offer challenging ideas.

It is my opinion that Professor Morey's well written article strikes directly at the fallacy of treating depreciation as an expense in accounting for hospital operations. It seems to me that what is "truth" in any area should be recognizable through scientific observation or logic. I believe that it can never be created by simple weight of opinion or by mere reference to authority. Thus it seems to me that truth in fixed asset accounting can be discovered primarily through logical application of principle.

The provable facts of fixed asset existence, identification, ownership, usage and eventual disposition do not "prove" that depreciation as defined in accounting is a recordable fact. We can hardly reach agreement in any discussion unless we define our terms and first agree that we are in fact discussing the same subject. Physical depreciation is one thing; accounting depreciation is quite another. Professor Morey properly points out that the concept of accounting depreciation is one that seeks to *allocate the costs* of fixed assets *to the income produced* through usage of those assets in order to measure gain or loss by time periods. Clearly there is no measurable relationship between fixed asset cost allocations and hospital revenue, even though the assets have been employed in serving those who benefit directly therefrom. The income-expense concept is a gain-loss concept applicable to profit seeking organizations but most certainly not appropriate to the activities of the public service organization. Good management in a business enterprise incurs expense in the belief that the service performed thereby will produce (either directly or indirectly) more income than its cost. The proper objective of management in a nonprofit organization, however, should be one that seeks to provide optimum service through efficient utilization of properties and direction of personnel.

Professor Morey has ably pointed out that hospital management faces not one but several problems in fixed asset accounting. Determination of the cost of performing hospital services is one problem; the measurement of cost in relation to income earned is another; the setting of equitable patient rates is a third; the measurement of operating efficiency is a fourth, and the finance of fixed asset acquisitions (both new and replacement) is yet another.

May I suggest that much of the current confusion in this area might be eliminated if a special committee were formed to study problems of accounting and finance for nonprofit hospitals? Provision should be made for representation of hospital controllers, hospital insurance plan managers, practicing certified public accountants, college accounting professors, and others who may have a real interest in these matters. If complete agreement cannot be reached, at least it may be possible to arrive at "general acceptance" of guiding ideas to be applied in accounting for nonprofit hospitals.

Ralph L. Boyd
Professor of Business Administration
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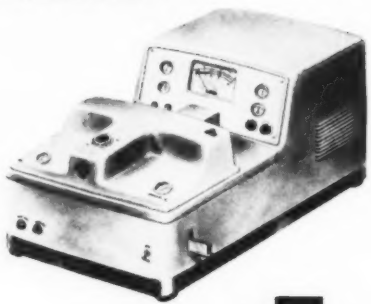

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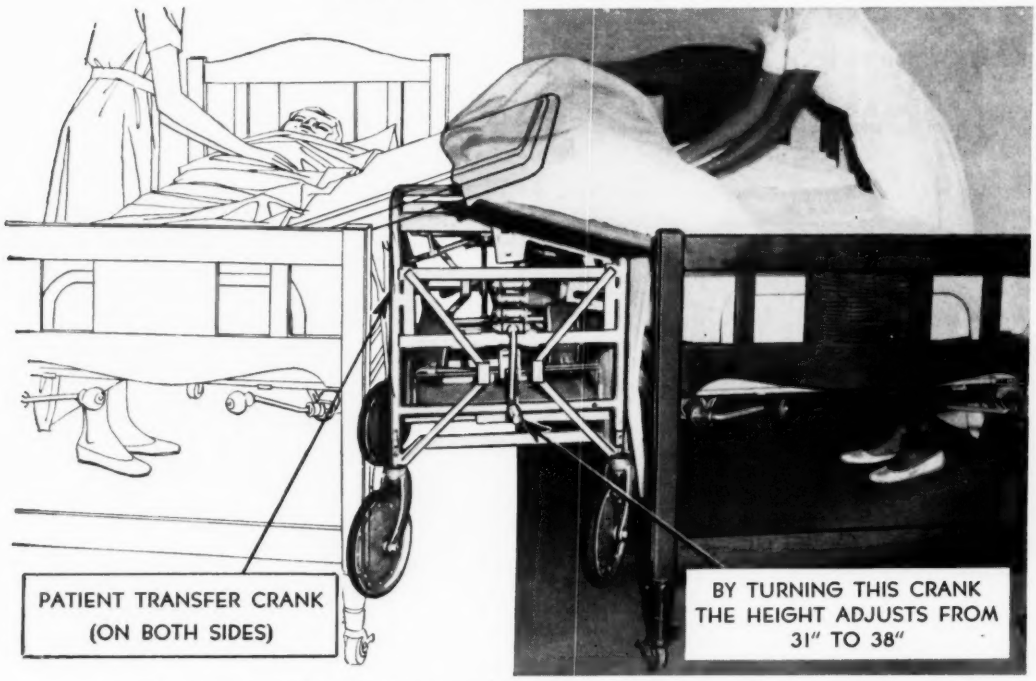

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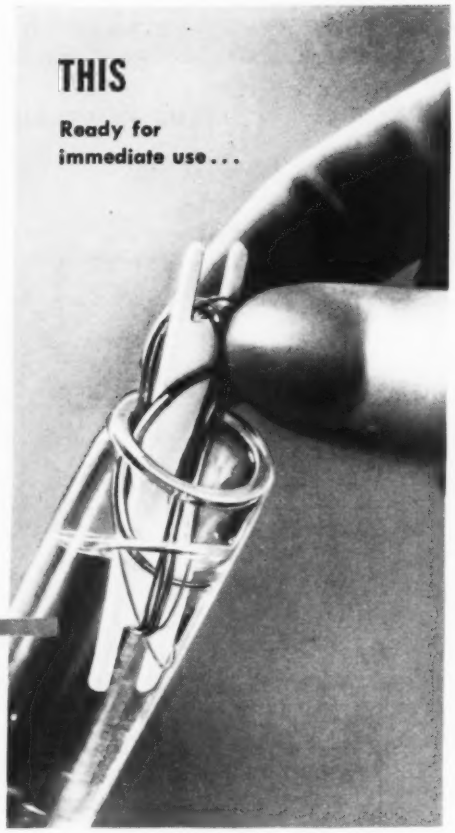

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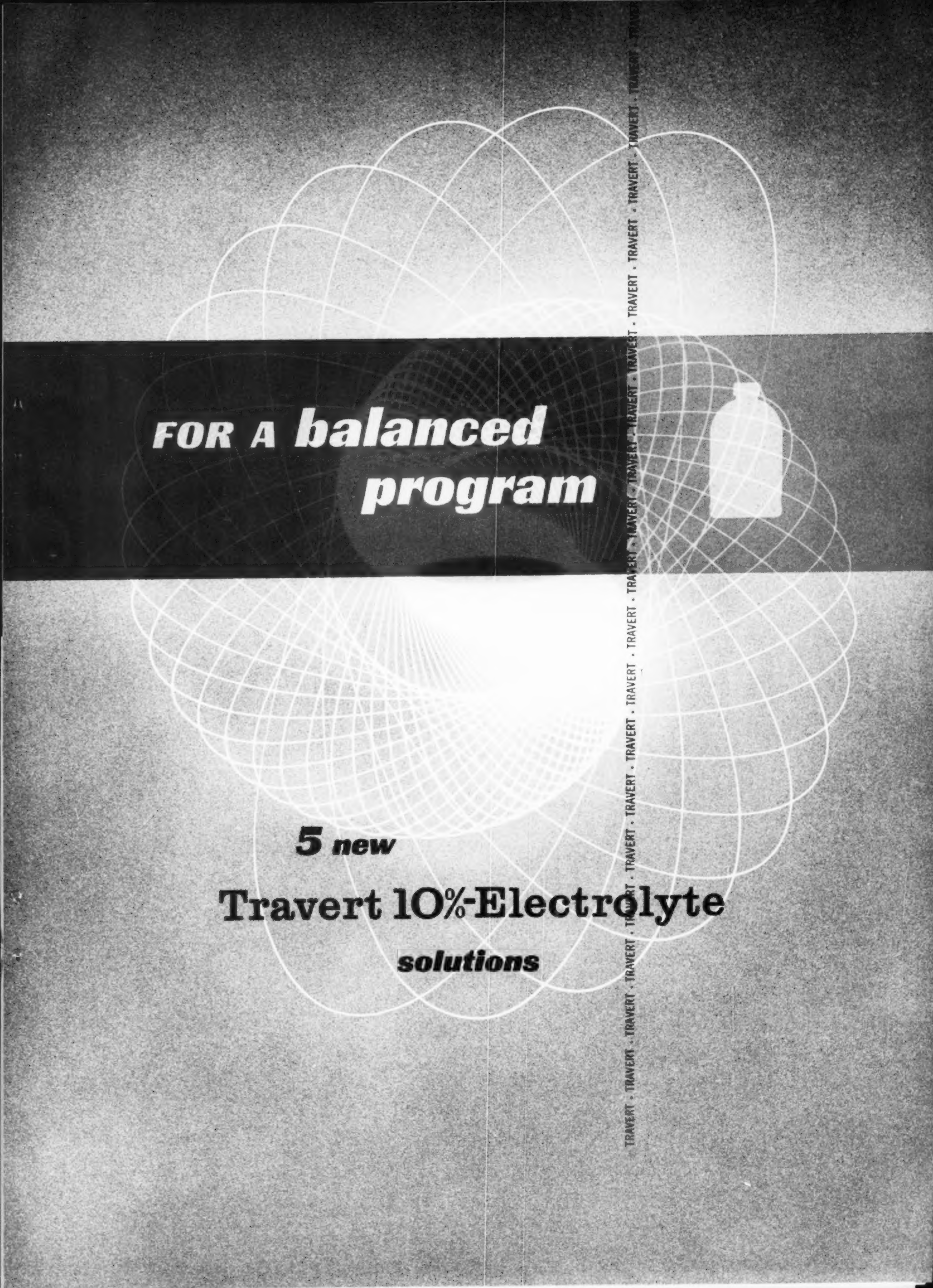
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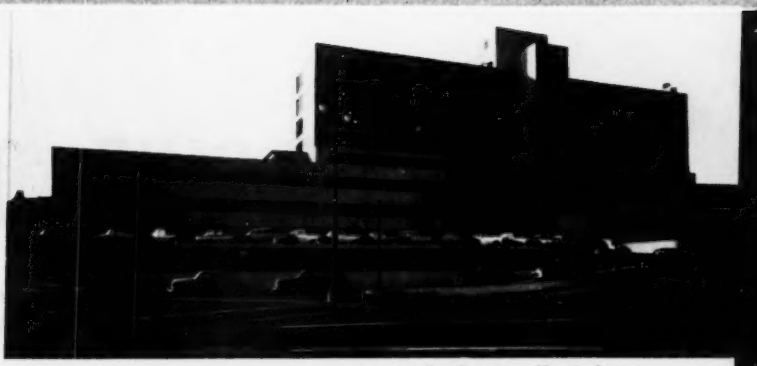

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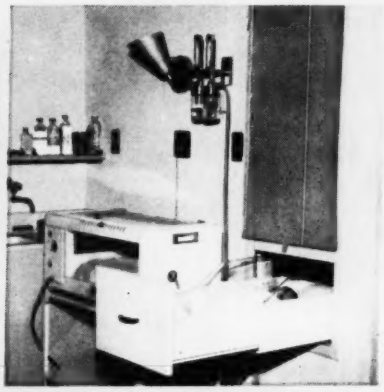

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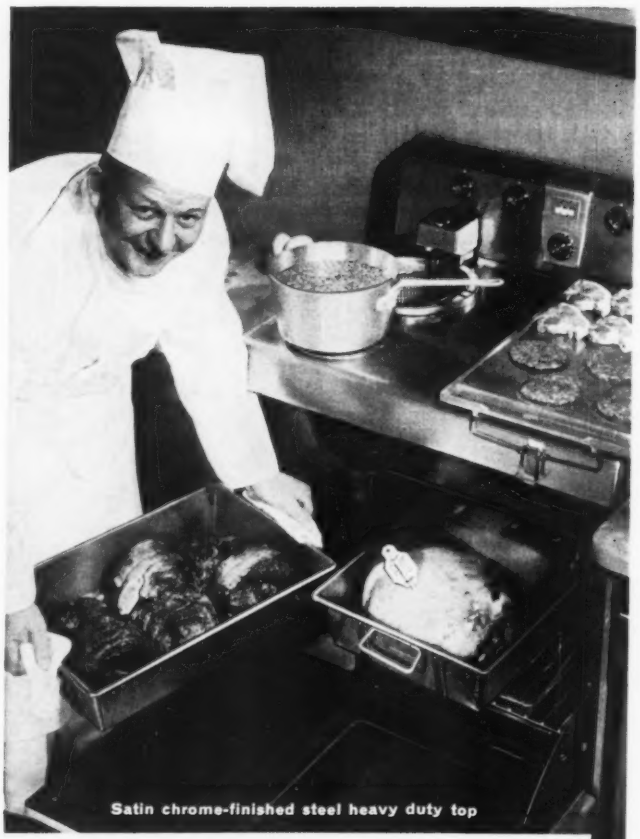

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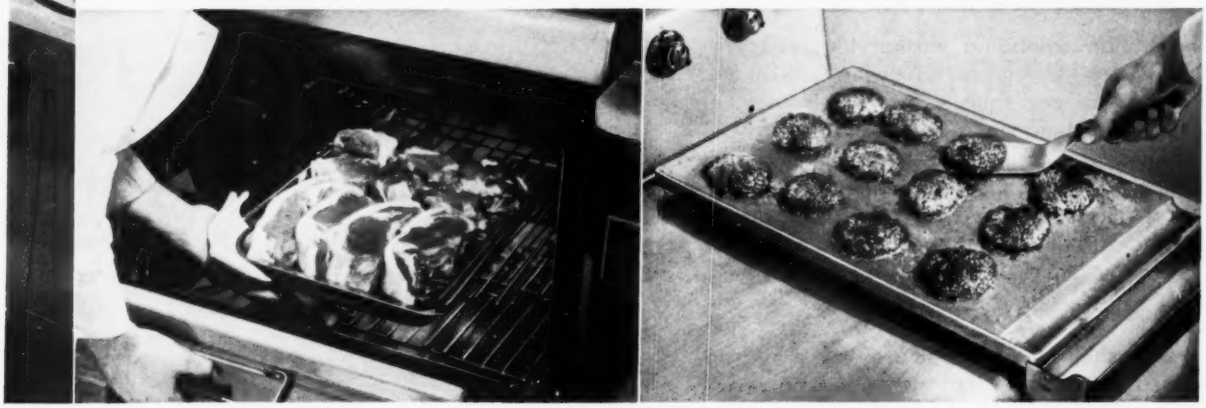
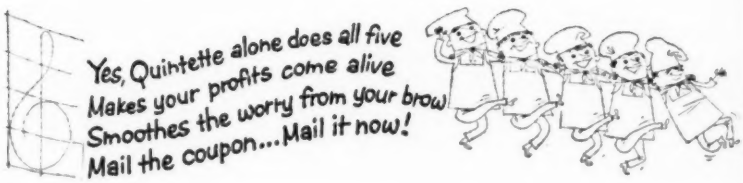


4 **IT'S A BROILER**—capable of broiling 48 12-oz., 1-inch thick strip-steaks an hour.

5 **IT'S A GRIDDLE***—griddles 288 3-inch, 2-oz. hamburgers an hour.

*Optional at extra cost



Hotpoint Co., Commercial Equipment Dept.
229 South Seeley Avenue, Chicago 12, Ill.

☐ Please send us full information on the Hotpoint *Quintette*.

☐ Please send a representative to demonstrate and explain the Hotpoint *Quintette*.

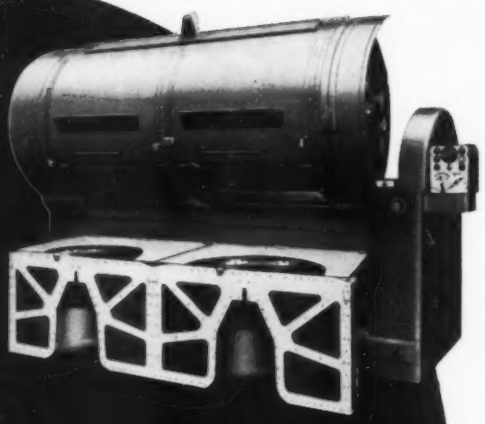
Name_____

Address_____

City_____ County_____ State_____

EASIER MAINTENANCE

. . . for sustained higher laundry production in the same floor area



the HOFFMAN unloading washer

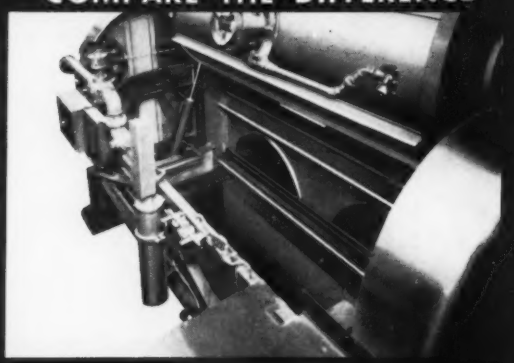
All Stainless Steel
Models with 42" Cylinders
for 225, 350, and 400 lb. loads

Here's an unloading washer that keeps its promise — goes right on giving you higher production per square foot. Even at times when maintenance is needed, the Hoffman Unloading Washer goes back into service quickly because these distinctive design features permit you to make repairs and adjustments with the utmost speed and ease:

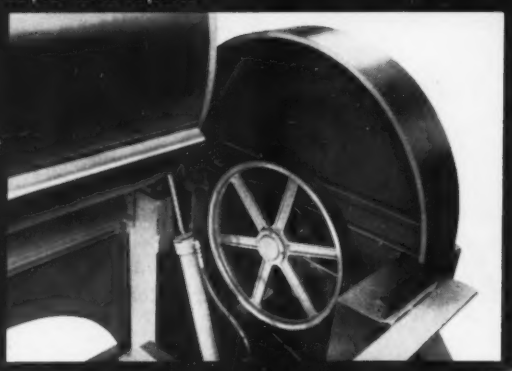
- No major disassembly needed for ordinary repairs
- Both shell and cylinder are raised hydraulically for loading, at the same time exposing all working parts
- Simplified V-belt and chain drive are easy to repair — easy to reach for adjustment

Write for Bulletin A-851

COMPARE THE DIFFERENCE



Above. Shell and cylinder shown in raised position. Note complete accessibility of all working parts, including dump valve, to permit rapid maintenance. Below. Close-up of V-belt and chain drive, for washer drive. Ultra-simple to adjust and repair.

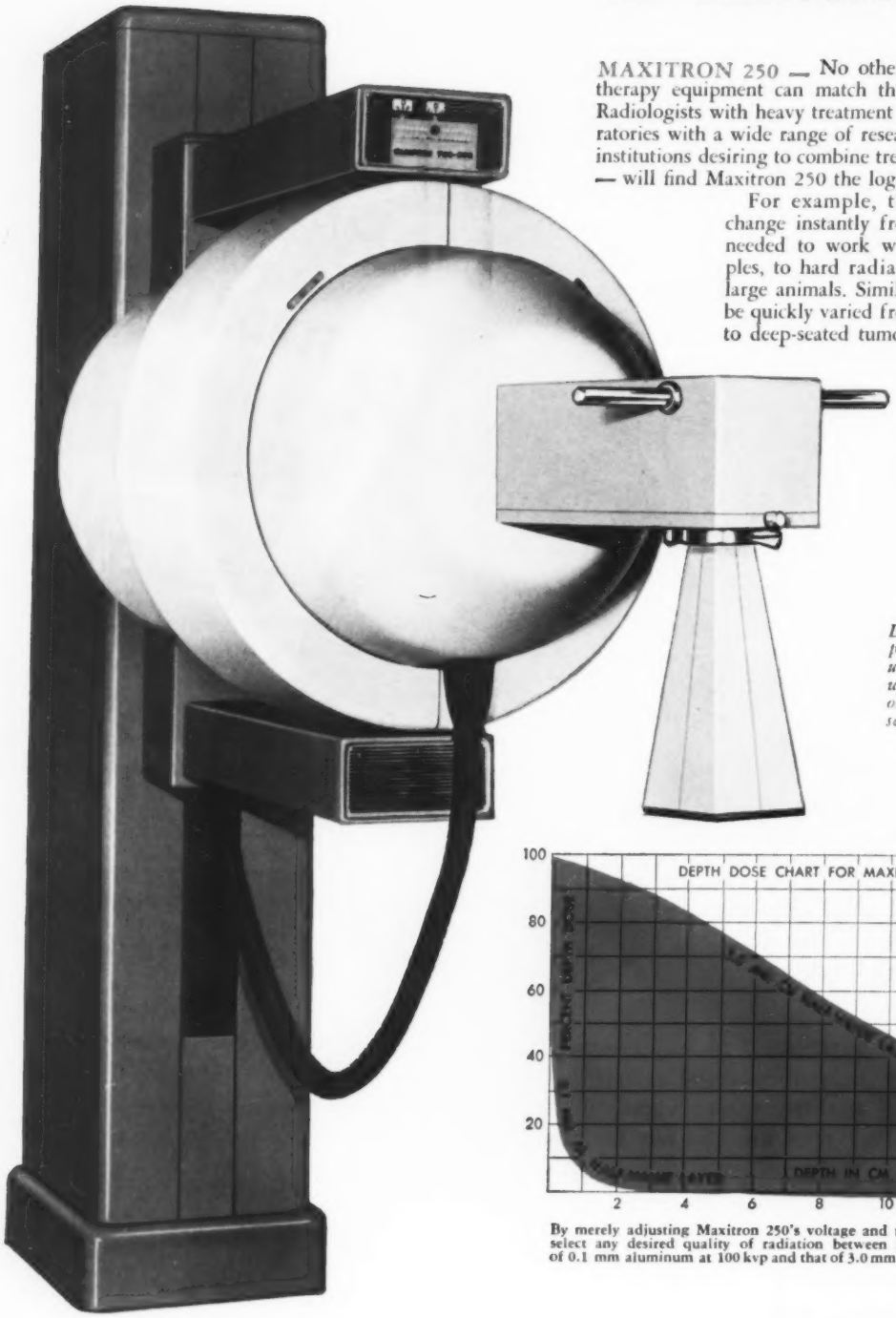


INSTITUTIONAL ... DIVISION

Hoffman

U. S. HOFFMAN MACHINERY CORP. 105 FOURTH AVENUE, NEW YORK 3, N. Y.

G. E. gives you a choice to match your



MAXITRON 250 — No other medium-voltage therapy equipment can match this unit's versatility. Radiologists with heavy treatment schedules . . . laboratories with a wide range of research projects . . . or institutions desiring to combine treatment and research — will find Maxitron 250 the logical selection.

For example, the laboratory can change instantly from soft radiation, needed to work with biological samples, to hard radiation necessary for large animals. Similarly, treatment can be quickly varied from superficial areas to deep-seated tumors. Under all conditions—at voltages from 100 to 250 kvp with tube currents up to 30 ma — dosage control is precise.

Like all G-E x-ray apparatus, either of these units can be yours — without initial capital outlay — on the Maxiservice® rental plan.

By merely adjusting Maxitron 250's voltage and filtration, you can select any desired quality of radiation between a half-value layer of 0.1 mm aluminum at 100 kvp and that of 3.0 mm copper at 250 kvp.

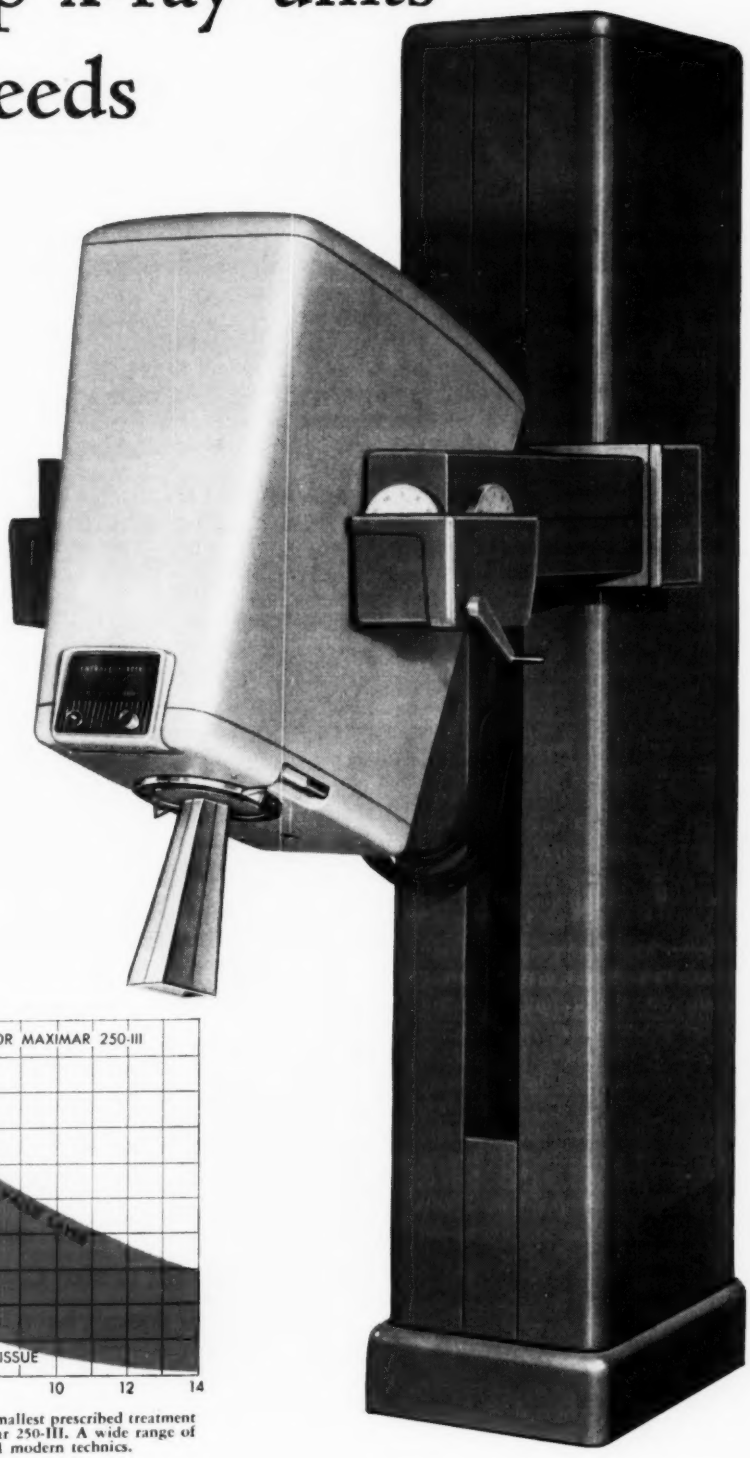
You can put your confidence in —

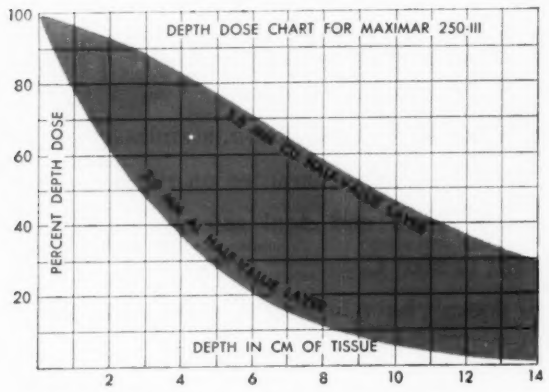
# of 250-kvp x-ray units therapy needs

MAXIMAR® 250-III — For normal hospital loads, here's a single x-ray unit that meets complete superficial, intermediate and deep therapy needs. Maximar 250-III's remarkable flexibility is based on its small head size . . . on its variety of cones and filters . . . on its wide range for continuous therapy from 80 to 250 kvp at 15 ma.

As in all General Electric x-ray units, uniformly high-quality radiation is achieved thanks to advanced design and manufacture. Combine this with a record of dependable operation and low maintenance cost—and you have the reasons for the popularity of the Maximar 250-III.

Why not discuss your therapy requirements with your G-E x-ray representative? If they call for 250-kvp apparatus one of these two units should be the answer. To get illustrated literature, write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, for Pub. H52.





Accurate control of radiation — to the smallest prescribed treatment area — is quickly achieved with Maximar 250-III. A wide range of treatment cones are available to cover all modern technics.

GENERAL ELECTRIC

Now No Need to Wait or Substitute for FREAS DRY AIR STERILIZERS

We have greatly increased our production over the last few months. Now we can **ship from stock** *many items that quality-conscious men like you waited months to get.* **Ask your laboratory supply dealer.**

Specify FREAS First ...to Last!

FREAS OVENS are built to serve 20 years or more, even in corrosive atmospheres. They are finer than ever.

Baked enamel *or* stainless steel exterior. Welded steel construction, thick glass wool insulation, stainless steel interior. Unconditional 5-year guarantee on ribbon element welded heater bank and dual safety hydraulic thermostat. Range to 260° C.

If your dealer doesn't have in stock the Freas Model of your choice, he can get these models promptly—601, 605, 625, 831, 120, 124, 40 and 50.

Precision Scientific Company

3725 West Cortland Street **Chicago 47**

Write for FREAS and THELCO Catalog No. 331

1. Kalistron A transparent vinyl "coat of armor" shields this rich wall covering . . . its color is fused to the underside. Virtually impervious to scratches, scuffs, stains, roughhouse. A damp cloth cleans it. 33 colors. Marvelous Kalistron adhesive prevents open seams. Ideal wherever traffic is heavy. Also made in matching upholstery grades.

2. Flexwood Genuine wood panelling in flexible form. Hence, you can curve it, wrap it around posts, get stunning matched grain effects over wide areas. Meets fire code requirements. Over 1.7 million feet installed in 1953. Every installation guaranteed. Widely used in banks, offices, public rooms, etc., for new construction and alteration jobs.

3. Kalitex Gives more protection than any other wall covering at anything like the price. Made much like Kalistron, with the same vinyl-protected beauty. Low in cost, yet its luxurious rough textured pattern is distinctive. Combines relatively low cost with great beauty and durability. Superb in hospitals, hotels, public buildings, etc.

4. Randomwood Similar to Flexwood except the shading of the wood varies, giving an interesting "random" effect. Use it where imagination is high but budget is low. May be hung by any good mechanic. Effective for a whole room or a dramatic single wall, in homes, small offices, anywhere. First cost is last cost for years.

Where there's a wall . . . there's a way to cover it at the wall covering division of United States Plywood Corporation. Here, at "Wall Center, U. S. A.," you will find answers to your most challenging wall questions. As, for example:

How can I achieve the beauty and richness of genuine wood on curving walls and rounded pillars?

How, in hospital and hotel rooms, can I avoid frequent paint jobs and high maintenance costs?

How can I cover a corridor wall that must stand up to scratches, scrapes, collisions?

How can I give a low-budget living room or office the distinction of wood panelling?

The answers, supplied by the products described here, are yours at "Wall Center, U. S. A." Read about them. Then send coupon below for additional information.

United States Plywood Corporation
World's Largest Plywood Organization
The Mengel Company

UNITED STATES PLYWOOD CORPORATION
Dept. K-117, 55 West 44th St., New York 36, N. Y.
(In Canada: Paul Collet & Co., Ltd., Montreal)

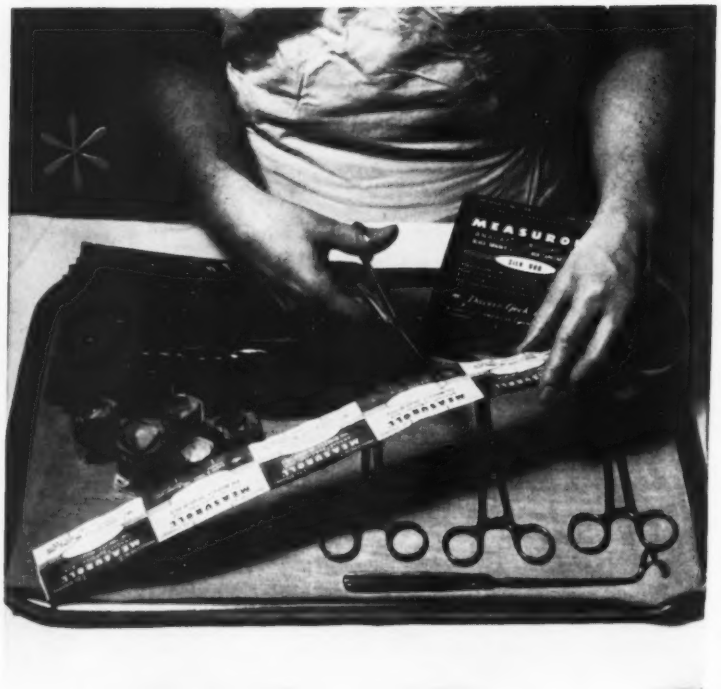
Please send information on products checked:

☐ **Kalistron** ☐ **Flexwood**
☐ **Kalitex** ☐ **Randomwood**

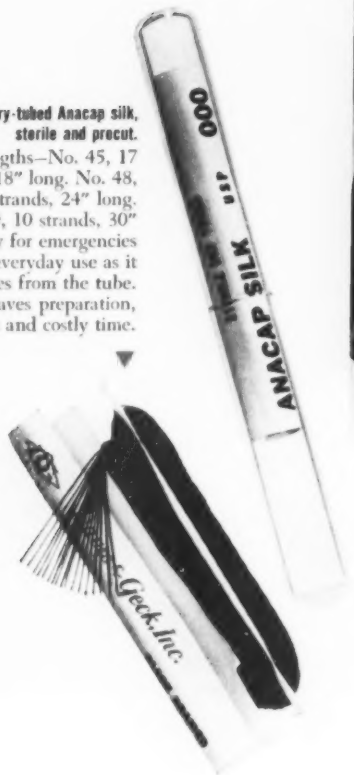
Name_____

Address_____

City_____ State_____



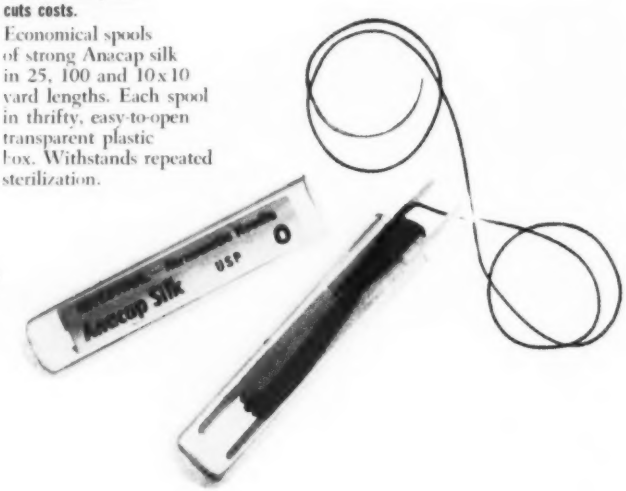
Dry-tubed Anacap silk, sterile and precut.
3 lengths—No. 45, 17 strands, 18" long. No. 48, 13 strands, 24" long. No. 49, 10 strands, 30" long. Ready for emergencies and everyday use as it comes from the tube. Saves preparation, expense and costly time.



Here's the latest D & G time-saver to speed up operating room procedure. Now, with the new Measuroll dispensing package, you can give each surgeon *exactly the length of Anacap silk he specifies*. Save time by cutting sutures any desired length, 20 strands at a time, from this handy, no-waste "tape measure," 10 yards long. Save more time by faster threading, for strands will not "bush." Save labor—no winding on spools. And remember, Measuroll protects sutures through autoclaving and keeps them sterile until use. Measuroll identifies the size and product right up to the time it is used. Use coupon below—send for Measuroll and *prove* all the time and work it saves!

Spooled Anacap silk cuts costs.
Economical spools of strong Anacap silk in 25, 100 and 10 x 10 yard lengths. Each spool in thrifty, easy-to-open transparent plastic box. Withstands repeated sterilization.

Tubed silk.
Anacap and twisted silk with Atraumatic® (eyeless) needles attached. Saves cleaning, washing, threading and sterilizing necessary with old style eyed needles.



new Measuroll* pack of Anacap® Silk

With "tape measure" markings you cut sutures any length... 20 strands at a time

D & G Anacap silk answers your 3 "musts" for quality silk sutures. It is smooth, flexible and strong. There's more silk per suture. *Greater tensile strength* permits use of smaller sizes. Thus *wounds heal faster* through more accurate approximation, better hemostasis and less tissue reaction. Anacap silk is absolutely non-capillary and has continued strength after many sterilizations.

▲ **Pre-threaded Anacap silk.**
No. 991. 18" lengths of Anacap black braided silk on 1¾" straight taper milliner needles. 6 to a packet, 24 packets to a box. Ready to be sterilized. Size 000 only.

Davis & Geck INC.
a unit of American Cyanamid Company

Danbury, Connecticut

To hospital staffs:
◀ Complimentary offer

DAVIS & GECK, INC.
DANBURY, CONN.

Please send sample of Anacap silk, size_____, cut from Measuroll, for trial.

name_____

hospital_____

city_____ zone_____ state_____

She's Proud and Happy . . . and so are We!

This smiling young lady is being awarded the 1,000th nursing scholarship given through the Florists' Telegraph Delivery Association.

She is Miss Mary Lou Duble of Galveston, Texas, a student nurse at St. Joseph's Hospital, Houston, Texas. With her is Mr. James Lawrie, president of the F.T.D.A.

Home-town member florists throughout the country have financed these scholarships through their contributions to the F.T.D.A. Nursing Scholarship Fund. They are proud to have made possible careers in nursing to 1,000 fine American girls—who in turn have dedicated themselves to the welfare of all America.

FLORISTS' TELEGRAPH DELIVERY — Send Flowers Worldwide — INTERFLORA

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FLORISTS' TELEGRAPH DELIVERY ASS'N

Headquarters: Detroit, Michigan

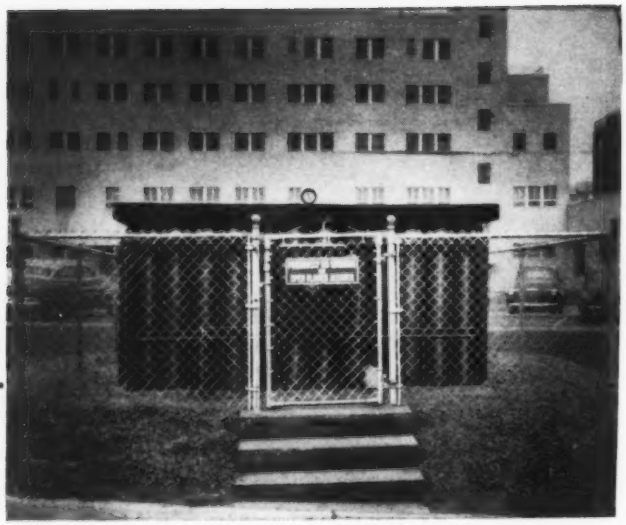
in
RUBBER-ELASTIC
bandage
you need elasticity
for compression
plus
body for support

ACE® RUBBER-ELASTIC BANDAGE

LINDE

Trade-Mark

OXYGEN SUPPLY UNITS FOR PIPING INSTALLATIONS



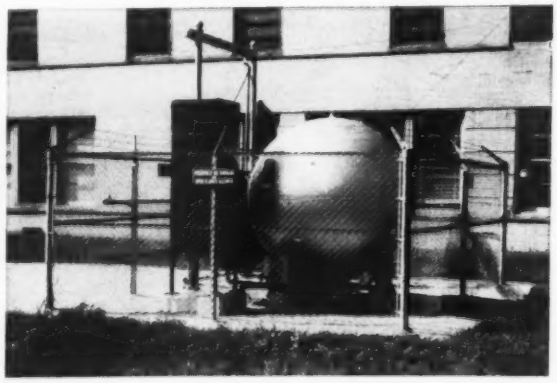
CASCADE oxygen storage unit

Whether your hospital is small, medium, or large, an oxygen piping distribution system will enable you to administer oxygen more efficiently and economically. But, whatever the size, the first requirement is a dependable oxygen supply unit.

For small installations LINDE's cylinder manifolds, located within the hospital, are best for supplying the system. Manifolds accommodating any practical number of cylinders are available. For larger systems, LINDE CASCADE and DRIOX oxygen storage units are the most reliable means of providing an uninterrupted flow of oxygen to the pipe line. These units, which are loaned to the hospital, are installed on the hospital grounds. LINDE keeps them supplied with oxygen, delivered in liquid form by special trucks.

A background of pioneering work and long experience qualifies LINDE to help you and your architect work out the design, installation, and operation of an oxygen piping distribution system.

LINDE will be glad to survey your hospital for a piping system, work with your architects on the details of its design, and offer unbiased suggestions for the most effective type of pipe line equipment for your particular needs. For further information call or write your nearest LINDE office today.



DRIOX oxygen storage unit

Linde

Trade-Mark

OXYGEN U.S.P.

LINDE AIR PRODUCTS COMPANY

A Division of Union Carbide and Carbon Corporation

30 East 42nd Street UCC **New York 17, N. Y.**

Offices in Principal Cities

In Canada: DOMINION OXYGEN COMPANY, LIMITED, Toronto

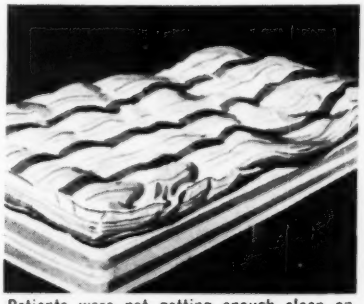
The terms "Cascade", "Driox", and "Linde" are registered trade-marks of Union Carbide and Carbon Corporation.

Here's why one Purchasing Agent switched to Firestone FOAMEX® MATTRESSES

BEFORE

Overworked nurses were forever complaining about the heavy work of lifting and turning old-fashioned mattresses. Said it kept them from other, more vital tasks.

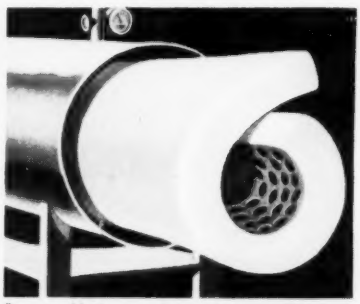
Mattress repairs were getting out of hand. Constant requisitions for new mattresses proved we were not getting our money's worth. Our bedding expenses were 'way out of line!



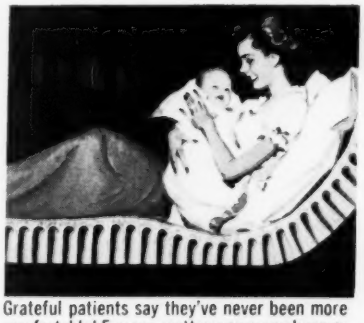
Patients were not getting enough sleep on their uncomfortable, lumpy mattresses. They never seemed able to settle down to a good night's rest. And rest is a hospital "must"!

AFTER

"A cinch to handle," nurses said about Foamex mattresses. "They never need turning and make the smoothest bed." Our labor costs went down and our nurses' morale went up!



Foamex Mattresses have given us years of wear! They withstand constant wetting... pests leave them alone. And how they stand up under washing and sterilization!



Grateful patients say they've never been more comfortable! Foamex mattresses never lump or sag... cut down on bed sores and other irritations. They're a "rest cure" in themselves!

ARE YOU THINKING OF BUYING NEW MATTRESSES?

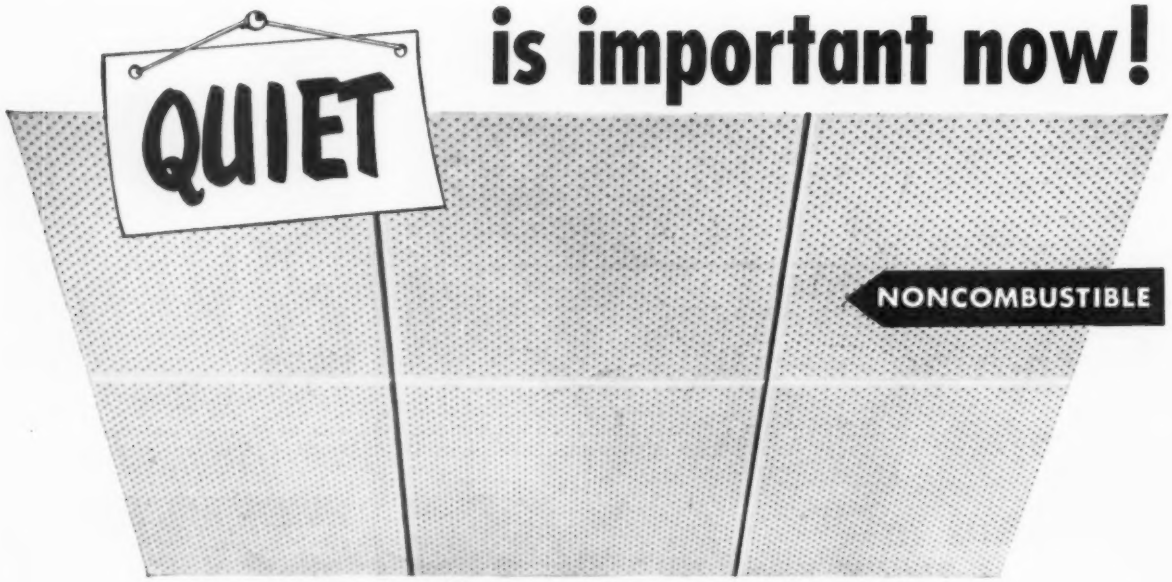
Contact your local Foamex Mattress supplier or get in touch with any of the Foamex Sales Offices listed below. See for yourself the superior construction of the new Foamex Mattresses. They'll give you years and years of clean, fresh service because they're backed by the Firestone label, your guarantee of quality.

CUSHIONED WITH FOAMEX BY Firestone

Guaranteed by Good Housekeeping

FOAMEX SALES OFFICES:

Fall River, Mass. • 28 West End Ave., at 61st St., New York 23, N. Y. • 1620 So. 49th St., Philadelphia 43, Pa. • 1200 Firestone Pkwy., Akron 17, Ohio • 200 So. Missouri Street, Indianapolis, Indiana • 26 East 16th Street, Chicago 16, Illinois • 4232 Forest Park Boulevard, St. Louis 8, Missouri • 502 Exposition Avenue, Dallas 1, Texas • 2525 Firestone Boulevard, Los Angeles, Cal. • 4300 Brighton Boulevard, Denver 16, Col. • Baum & Negley, Pittsburgh 6, Pa. • 480 Lindbergh Drive, N.E., Atlanta 5, Ga. • 958 Harrison Street, Seattle 9, Washington • Firestone Boulevard, Memphis 7, Tenn. • 652 Stinson Boulevard, Minneapolis 13, Minnesota



Sanacoustic* Ceilings provide strength-building, relaxing quiet so necessary to patients' progress

In modern hospitals today, sound control is considered essential to the welfare of patients. *Quiet* speeds recovery.

Sanacoustic Ceilings offer hospitals one of the most effective methods of combating harmful noise. They are highly efficient acoustically, and are also sanitary and noncombustible. Sanacoustic consists of *perforated metal panels* backed up with a fireproof, sound-absorbing element. The baked-enamel finish is easy to keep clean, and can be painted and repainted without loss of efficiency. Sanacoustic panels may be applied with new construction or over existing ceilings and are easily removed for access to services.

Other Johns-Manville Acoustical Ceilings include perforated *Transite** Acoustical Panels, recommended for those areas subject to excessive moisture; *Permacoustic**, a textured noncombustible tile; and *Fibretone**, a budget-priced drilled fibreboard unit.

For a free survey of your problems, or a free book on Sound Control, write Johns-Manville, Box 158, Dept. MH, New York 16, N. Y.

*Reg. U. S. Pat. Off.

JOHNS MANVILLE JM PRODUCTS

Johns-Manville

40 years of leadership in acoustical materials

Again St. Luke's Hospital

KANSAS CITY, MISSOURI

Chooses Simmons Metal Furniture

500 BEDS . . . ALL SIMMONS

The problem of furnishing the new 125-bed wing of St. Luke's Hospital was a simple one to solve. Simmons metal furniture had already established a dependable service record in the original 375-bed unit.

The soothing color, sheer comfort and lasting beauty of a Simmons hospital room ensemble work wonders in restoring health.

Add to these advantages the low-cost maintenance of steel, and you have the perfect combination of furniture features for hospital service.

One of the room groups selected by St. Luke's and illustrated above is in Simmons Dove Green. The harmonizing plaid upholstering on the chairs is sturdy, easy-to-clean Saran.

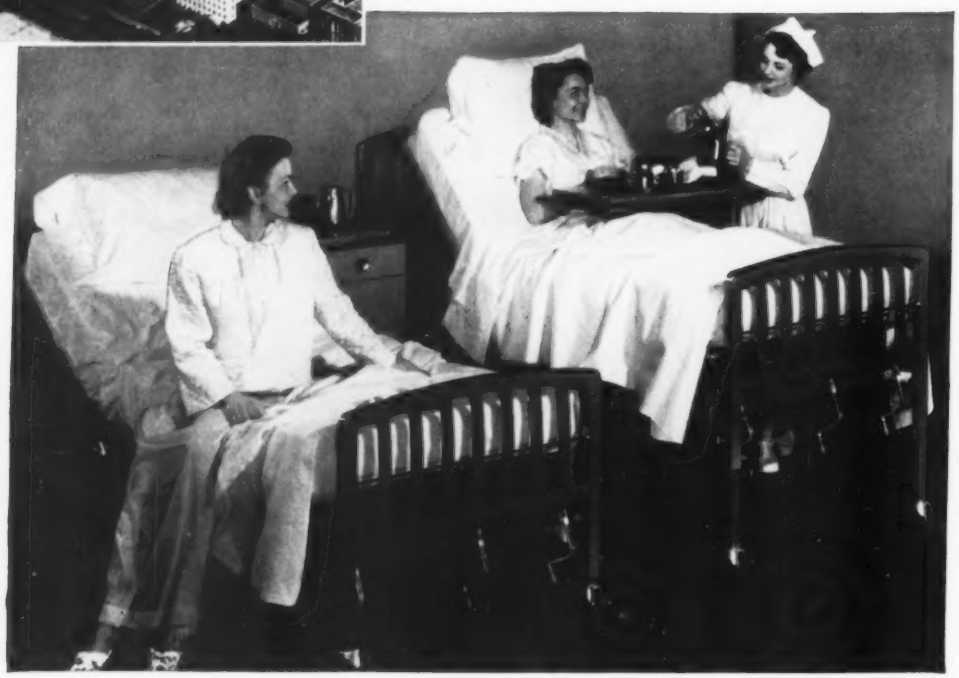
Whether you are modernizing or planning a new building, call on your Simmons hospital supply dealer for helpful advice.

CONTRACT DIVISION **Simmons Company**

Display Rooms: Chicago 54, Merchandise Mart Plaza
New York 16, One Park Avenue • Atlanta 1, 353 Jones Avenue, N.W.
San Francisco 11, 295 Bay Street • Dallas 9, 8600 Harry Hines Blvd.

Another hospital tested product from Simmons *Complete Line

SIMMONS · Furniture ·



Beth Israel acclaims Simmons *Vari-Hite* Bed Ends!

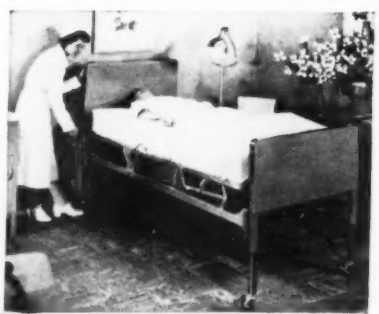
Writes Dr. Charles Wilinsky, Administrator of Beth Israel Hospital, Boston:

"In 1949 Beth Israel ordered 137 Vari-Hite Beds. Our experience proved that the many advantages of this bed make it much more desirable than the old-fashioned type with one standard height. We recently ordered 188 more Vari-Hite Beds to standardize on this equipment throughout the entire hospital."

In hospital after hospital, experience is confirming the advantages of Simmons' Vari-Hite Beds. Busy nurses find that beds which may be left at convenient low levels eliminate patient's fears of unfamiliar heights and enable ambulatory patients to get in and out of bed without assistance... thus, valuable staff time is saved, accidental falls are prevented and the need for foot stools is eliminated.

Yet when treatment is necessary, Vari-Hite Bed Ends can be easily and quickly raised to regular hospital height; can be adjusted to Fowler and Trendelenburg positions without elevating stems, bed blocks or similar equipment.

Vari-Hite Bed Ends can be equipped with all-purpose attachments, including safety sides and Balkan frame, fit all three Simmons Adjustable Springs. Available in full panel and seven filler styles. See your hospital supply dealer or write your nearest Simmons office for full information on Vari-Hite.



Vari-Hite Bed ends are adjustable to any height with a few turns of a crank. Fowler or Trendelenburg positions may be obtained by cranking ends to different heights.

Display Rooms:
Chicago 54, Merchandise Mart
New York 16, One Park Avenue
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SIMMONS COMPANY
HOSPITAL DIVISION

Real clay tile—immune to most problems

Normal and necessary hospital procedure is good for patients but bad for almost any material except real clay tile. American-Olean Tile thrives on abuse and stays bright despite constant scouring with harsh disinfectants. It does not need costly repainting, refinishing, or repairs. Your first cost is your last, with A-O Tile!

TILE SPECIFICATIONS: Color Plate 332. Walls: 63 Flax Blue. Cap and Base: 65 Iris Blue. Floor: 2⅜" Golden Range Varitone with Maroon Textone Border.

CONDUCT-O-TILE eliminates main causes of anesthetic explosions.

Newly-developed vitreous ceramic tile dissipates dangerous charges of static electricity. Permanently conductive, without waxing or other special treatment. No free carbon to bleed out or track. Send for complete technical data.

American-Olean Tile Co.

Executive Offices: 1041 Kenilworth Ave., Lansdale, Penna.
Factories: Lansdale, Pennsylvania • Olean, New York
Member Tile Council of America

AMERICAN-OLEAN TILE COMPANY
1041 Kenilworth Ave., Lansdale, Pa.

Please send me, without charge,

☐ Information and literature concerning CONDUCT-O-TILE.
☐ Booklet 204, Catalog of Tile Products.

Name.....
Hospital.....
Street.....
City..... Zone..... State.....

You'll like McKesson's "Personalized Service"

More and more, busy hospital pharmacists are coming to depend on the conscientious, *personalized* service given by their McKesson & Robbins representative. Here are some of the benefits to you:

PERSONAL SERVICE . . . not only does the McKesson representative call on you at regular intervals, but a telephone call to the McKesson Division serving you will provide rush shipments in emergencies.

COMPLETE STOCKS . . . McKesson carries the most complete line of pharmaceuticals in the field.

FAST DELIVERY . . . there's a McKesson wholesale division and warehouse ideally located to serve you.

LESS DETAIL . . . when you order through McKesson, you have only *one* invoice, only *one* shipment to open and check, only *one* representative to see.

If a McKesson representative is not calling on you, or if you wish more information, write to McKESSON & ROBBINS, INCORPORATED, 155 E. 44th St., New York 17, N. Y.

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READY TO SERVE YOU

For fast delivery, with a minimum of detail and a maximum of service, get in touch with your nearest McKesson Division.

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. . . indicates phase of sterilizing cycle in progress. Shows unelapsed time of exposure period (B).

. . . cross-the-room visibility that eliminates inspection trips.

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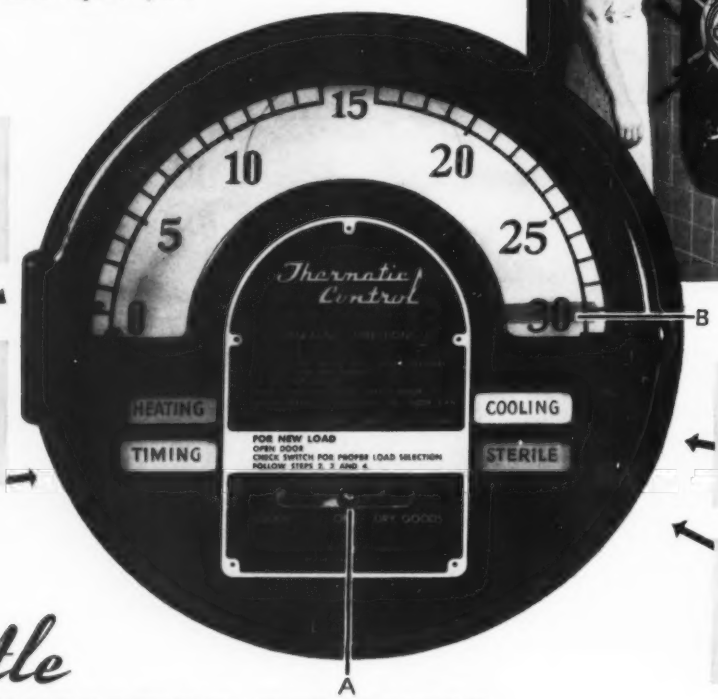
indicates heating of the chamber.

TIMING (Yellow)
indicates load being exposed to sterilizing temperature.



COOLING (White)
indicates sterilization complete and chamber pressure reducing.

STERILE (Green)
indicates sterile load ready for safe removal.

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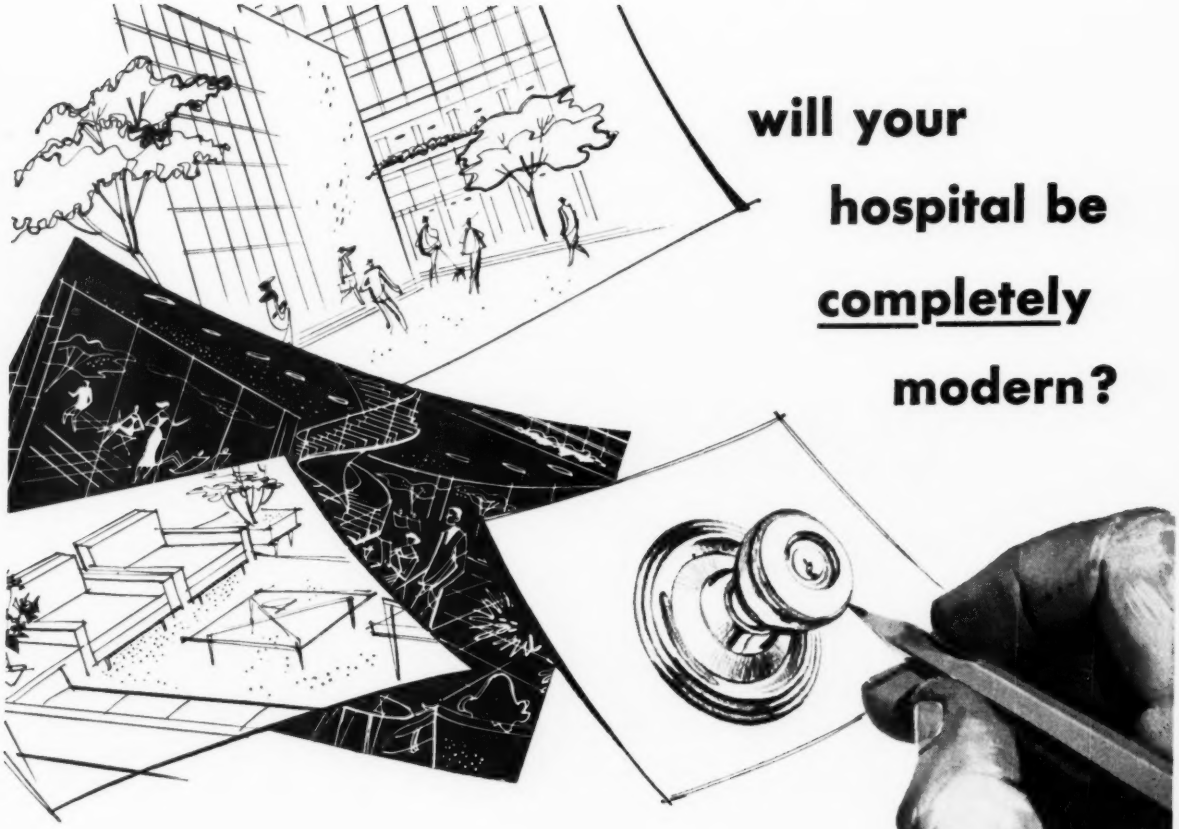

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For rapid, dramatic reduction
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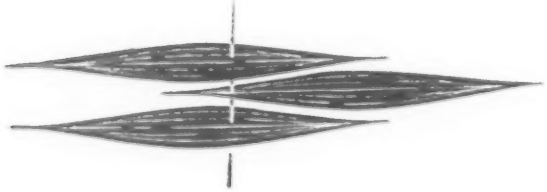

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rapidly reduces acute, local inflammation

in *phlebitis, thrombophlebitis, phlebothrombosis*
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Vials of 5 cc. (5 mg./cc.: crystalline trypsin suspended in sesame oil), by prescription only.

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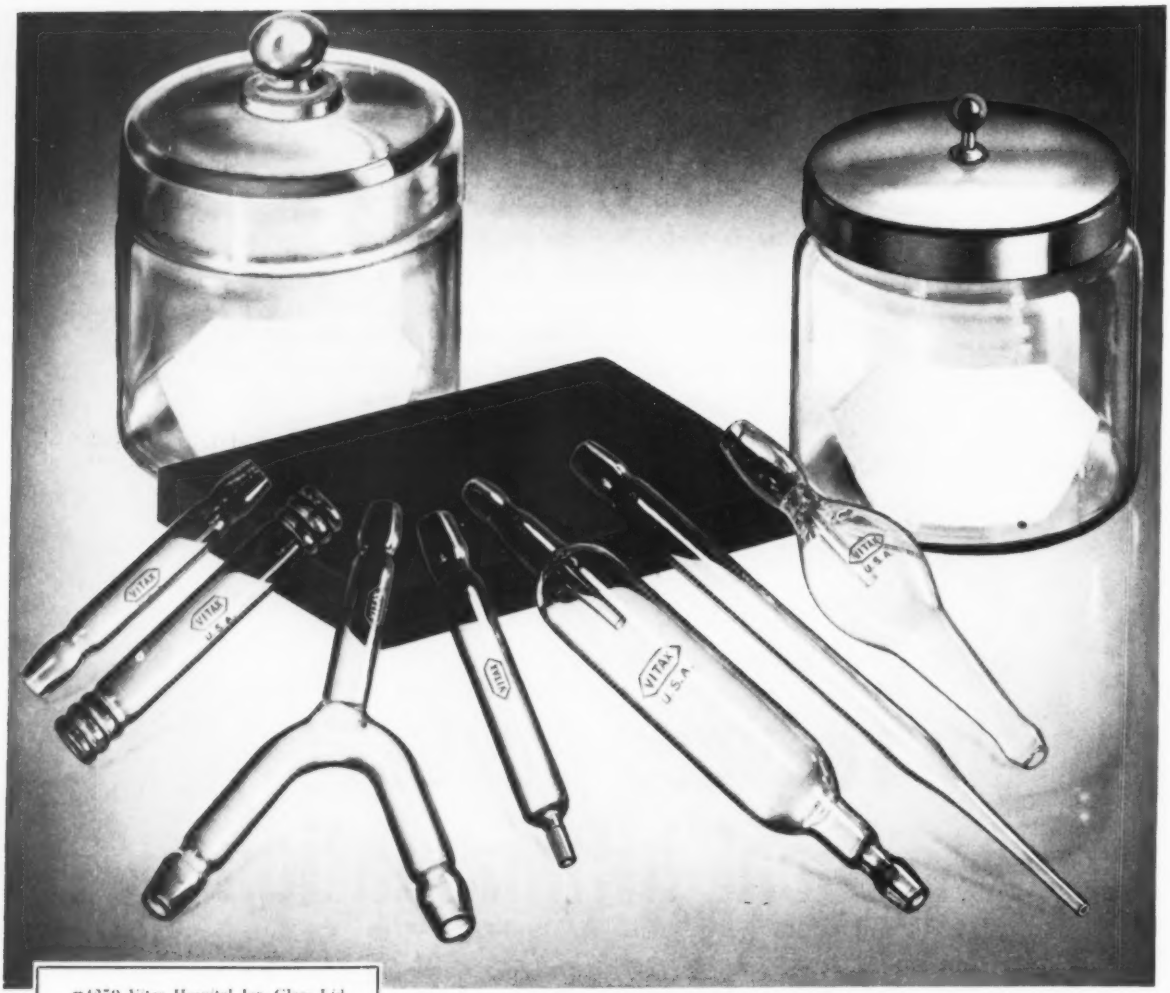

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That every hospital must put safety before economy goes without saying. How to keep costs down in the face of rising costs without sacrificing standards is a real problem.

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The VITAX trademark appears on each piece of VITAX glassware. Look for it; it is your assurance that you are getting the best in surgical glass. Specify VITAX always and be sure of getting safety . . . plus savings. Consult your hospital supply house.

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no other valve equals the Puritan leakproof anesthetic-gas cylinder valve

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POSITIVE SAFETY
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Here are the Supporting Facts:

This Puritan flush type valve is especially designed to dispense gases that liquefy under pressure . . .

It is completely leakproof because the valve contains no packing and therefore requires no adjustment. This also assures complete purity since no packing or lubricant comes in contact with the contents.

In addition, this Puritan valve opens or closes quickly and easily with just one complete turn of the hand wheel. Users of Puritan Maid anesthetic gases thereby realize a more economical use of the contents.

All Puritan cylinders with flush type valves purchased since January, 1953, have been PIN-INDEXED in accordance with the Compressed Gas Association safety specifications described in their folder V-3; free copy sent on request.

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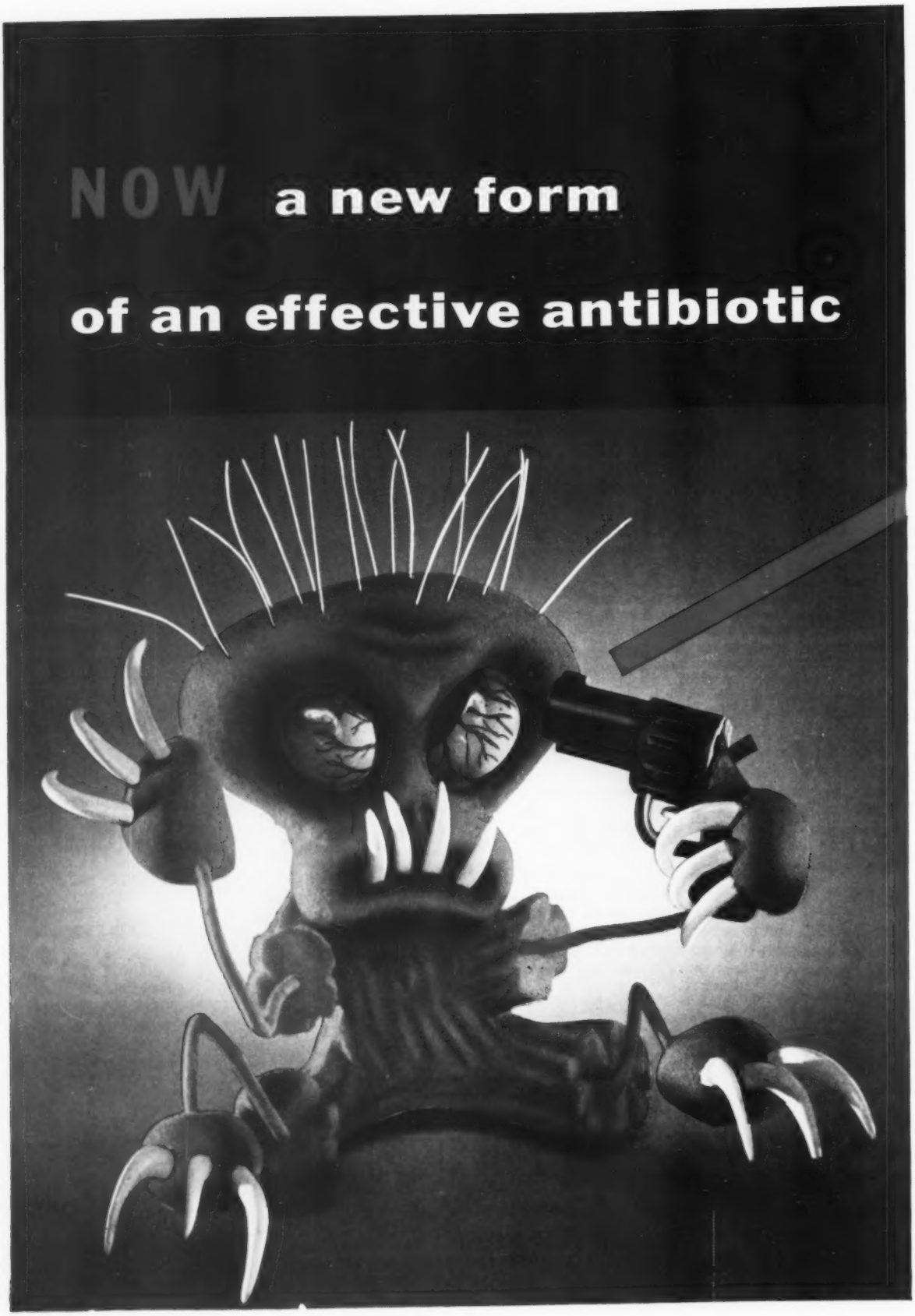

NOW a new form
of an effective antibiotic

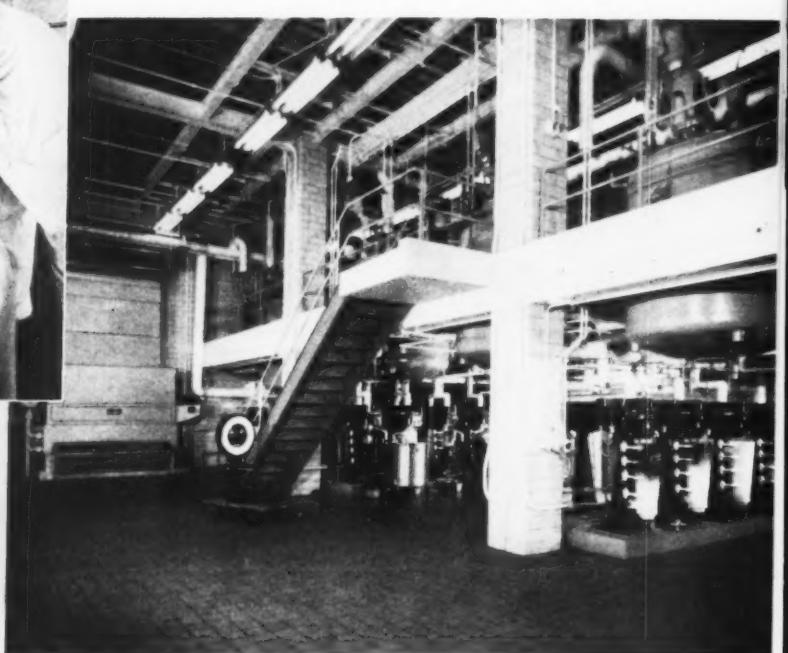
ARMOUR'S NEW LABORATORIES *producing*

Left: **Parenteral Packaging Department.** One of the areas completely air conditioned.

POWERS CONTROL

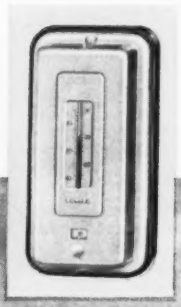
Above: **Hospital Gowned and Masked Technicians in Bulk Sterile Filling Area.** Here the air conditioning is treated in such a manner that aseptic operations could be undertaken with least possibility of bacterial contamination.

Below: **Low Temperature Human Blood Fractionation Plant** — *the largest in the U.S.A.* In this area there are processed 18,000 pints of human blood (or the equivalent of human plasma) weekly into Normal Serum Albumin and Poliomyelitis Immune Globulin. Processes are controlled by Powers V-Port FLOWRITE Valves. This entire room is accurately held at 23° F.

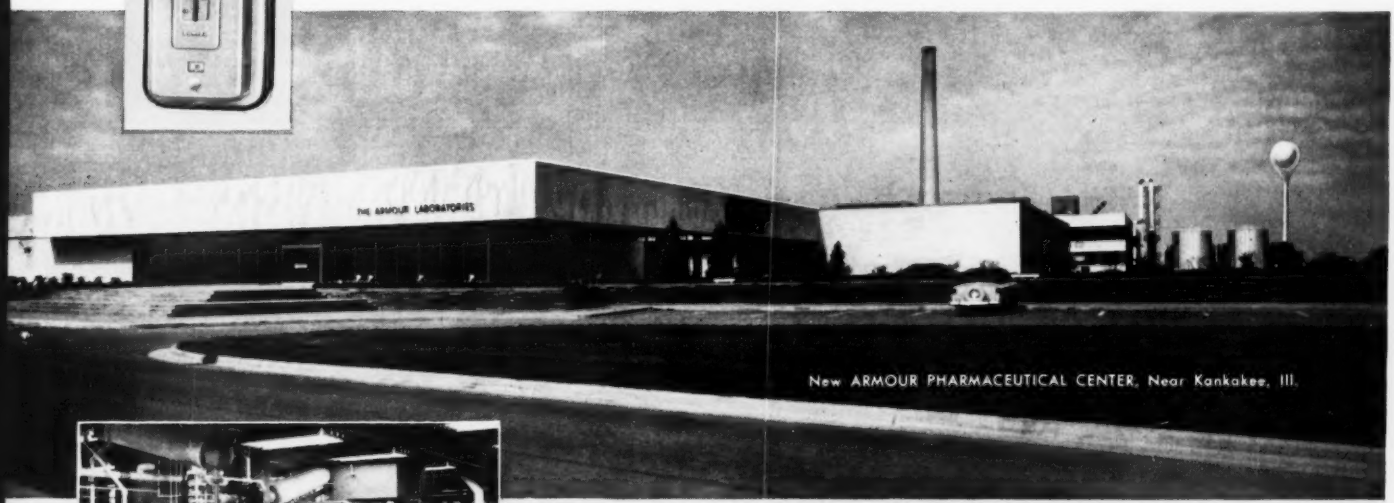


Above: **View in Parenteral Manufacturing Building No. 4** where ACTHAR, Insulin, and Intrinsic Factor (BIO-PAR) are processed. Processes here are also controlled by Powers V-Port FLOWRITE Valves.

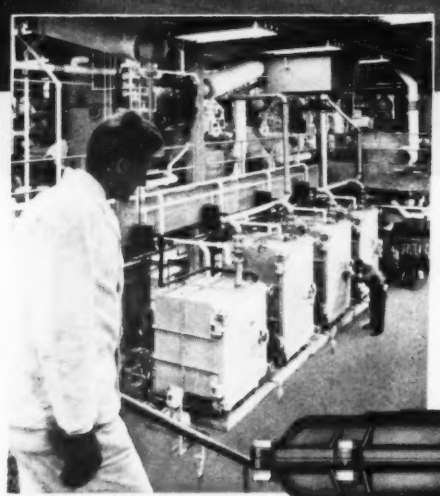
Gamma Globulin and other pharmaceuticals...



Use POWERS AIR CONDITIONING CONTROL AND FLOWRITE DIAPHRAGM VALVES



New ARMOUR PHARMACEUTICAL CENTER, Near Kankakee, Ill.



Above: **View in Solvent Extraction Building No. 5** where Insulin, Intrinsic Factor and Injectable Liver are produced. Processes are controlled by Powers V-Port FLOWRITE Valves.

Architects & Engineers: HOLABIRD & ROOT & BURGEE
Piping Contractor: M. J. CORBOY CORP.

Gamma Globulin for Combating Polio, Serum Albumin used by the Armed Forces for transfusion in shock and burn cases, Thyroid powder and tablets, Intrinsic Factor (BIOPAR), Insulin and ACTHAR for treatment of arthritis — production of these and many other Armour products requires accurate temperature control.

To insure the precision control of air conditioned areas in their modern $12 million plant Armour installed a Powers pneumatic control system.

To accurately control the flow of heating and cooling mediums and vacuum used for various processes, they installed Powers V-PORT FLOWRITE Valves.

When you have a control problem requiring the dependable performance assured by Powers products — call our nearest office or write us direct.

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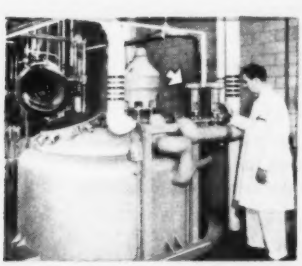

Powers FLOWRITE Valve
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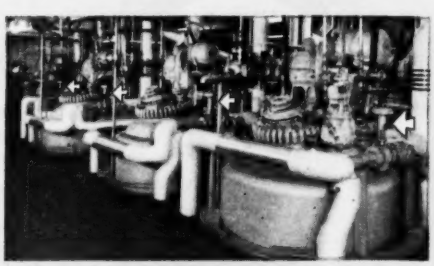
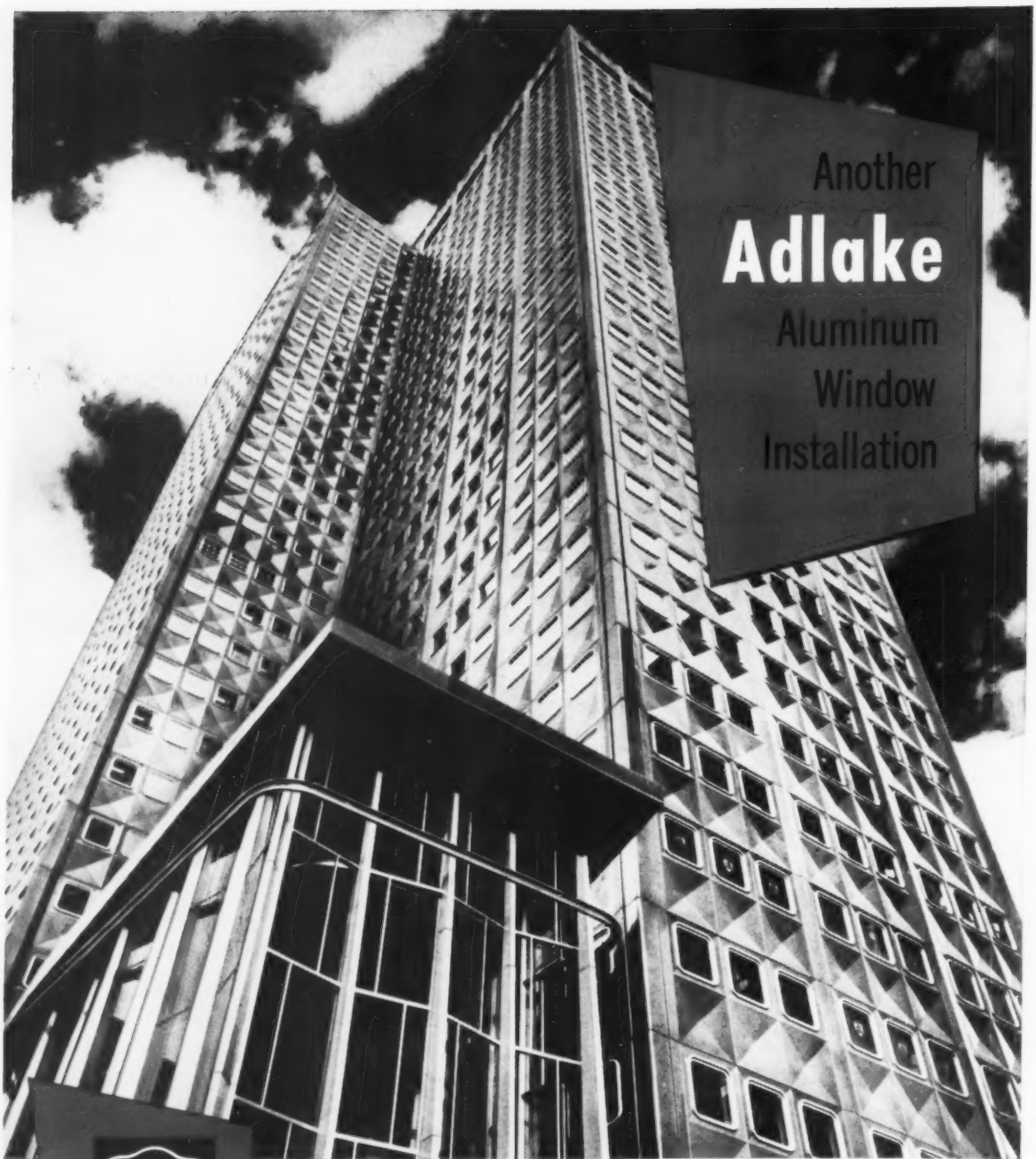
Gives BETTER Control with Less Maintenance

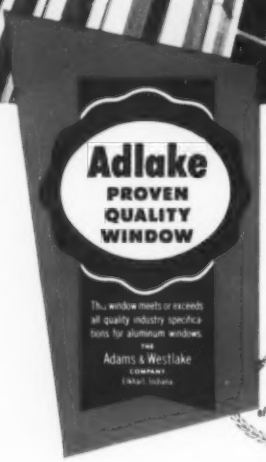
Over 100 are Used in Armour Laboratories.



ACCURATELY CONTROLS STEAM, WATER, VACUUM AND PROPYLENE GLYCOL AT ARMOUR LABORATORIES



The Alcoa Building, Pittsburgh, Pennsylvania Architects—Harrison & Abramovitz, New York
Associate Architects—Mitchell & Ritchey, Altenhof & Brown, Pittsburgh General Contractor—The George A. Fuller Co.



When buildings like Pittsburgh's Alcoa and Chicago's Prudential choose ADLAKE Aluminum Windows, you can be sure their builders have satisfied themselves that *there is no better window on the market!*

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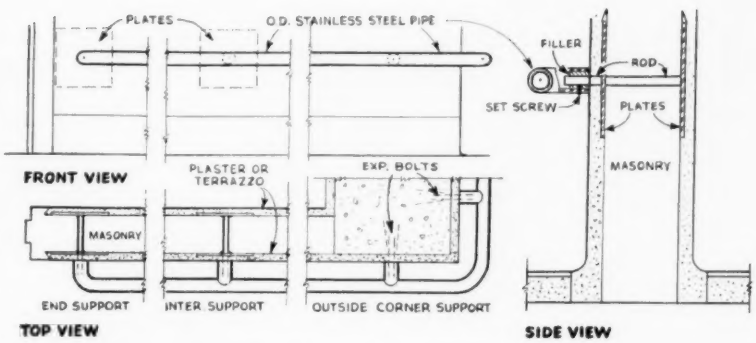
Small Hospital Questions

Protect Those Walls

Question: We are experiencing difficulty, as are many hospitals with which I am familiar, because of food trucks, wheel chairs, stretchers, and so on, scratching the wall in the corridors. In a recent issue of The Modern Hospital, one of the hospitals featured had a protective wall bumper or rail showing in one of the illustrations. Could you present details about this wall bumper, which would appear to be a reasonable solution to the problem.—R.L.P., N.Y.

ANSWER: The hospital shown was the Weld County General Hospital, Greeley, Colo., and the illustration of the wall bumper appeared in a picture on page 63 of the February 1954 issue of The MODERN HOSPITAL.

Queried for details of the wall bumper, architect Alan Fisher of Fisher and Fisher of Denver, submitted the accompanying sketch. "This item was considered by some to be a luxury at the time of installation, and we do not feel fully prepared now to evaluate the results," Mr. Fisher stated. "After a little more maintenance time has passed, the hospital will be in a better position to judge the benefits."



Working drawing of corridor bumper rail.

How to Foil Thieves

Question: We have a continuing problem of petty thievery. The records show that linens, table and kitchen ware, some foods, and other supplies are being stolen not in especially large quantities but with recurring frequency. What are the methods used for controlling thievery in hospitals?—B.C., Ill.

ANSWER: Of course, there is no single method of controlling thefts of different items in several hospital departments. Usually, careful inventory records and alert observation will show whether thefts are traceable to employes, patients, visitors or outside operators who have observed and are taking advantage of some weakness in the hospital's "security structure." For example, an unusual case came to light recently when one hospital was able to trace linen thefts to an employe of a near-by undertaking establishment.

At a recent hospital meeting, the subject of theft was discussed at length and various methods for control were suggested for various departments. The consensus of the group was that control of two of the most frequently stolen items, linens and drugs, could be achieved only by keeping linen and drug closets locked. Several administrators in the group emphasized the importance of taking employes into the confidence of management in connection with the problem of theft. "Many times we have found that employes will quickly spot a thief among their number, once they are aware of the problem," one administrator stated. "Instead of having the effect, as some have feared, of putting the guilty employe on guard, it has had the opposite effect of enabling us quickly to determine who is suspect and how thievery is being accomplished."

Conducted by Jewell W. Thrasher, R.N., Frazier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Maine, and others.

Those Advance Payments

Question: Should the hospital require a deposit or payment in advance at the time of admission on nonemergency patients?—D.W., Ill.

ANSWER: Where there is justifiable cause to doubt the patient's credit standing, and the hospital thus stands to lose unless an advance payment is required, prudent management demands that some payment or satisfactory arrangement for payment be made before a liability is incurred. On the other hand, many hospitals create problems by requiring deposits or advance payments from patients whose credit standing is satisfactory, and susceptible of quick checkup through community credit channels. With a large percentage of entering patients covered by some form of hospitalization insurance, the credit problem has diminished somewhat; more and more hospitals, too, are using the local credit bureau, retail association, chamber of commerce or other credit agencies to eliminate the necessity for demanding an advance payment, which often creates an unfavorable response on the part of the patient, his family and the public. At the very least, nonemergency admissions can be checked with the office of the attending doctor. Where credit information indicates the patient and his family are in good standing in the community, the hospital stands to gain, rather than lose, from a liberal credit and payment policy.

IN THE LAB—

It's easy to keep spic and span with long-lasting, easy-to-clean

VOLLRATH WARE!

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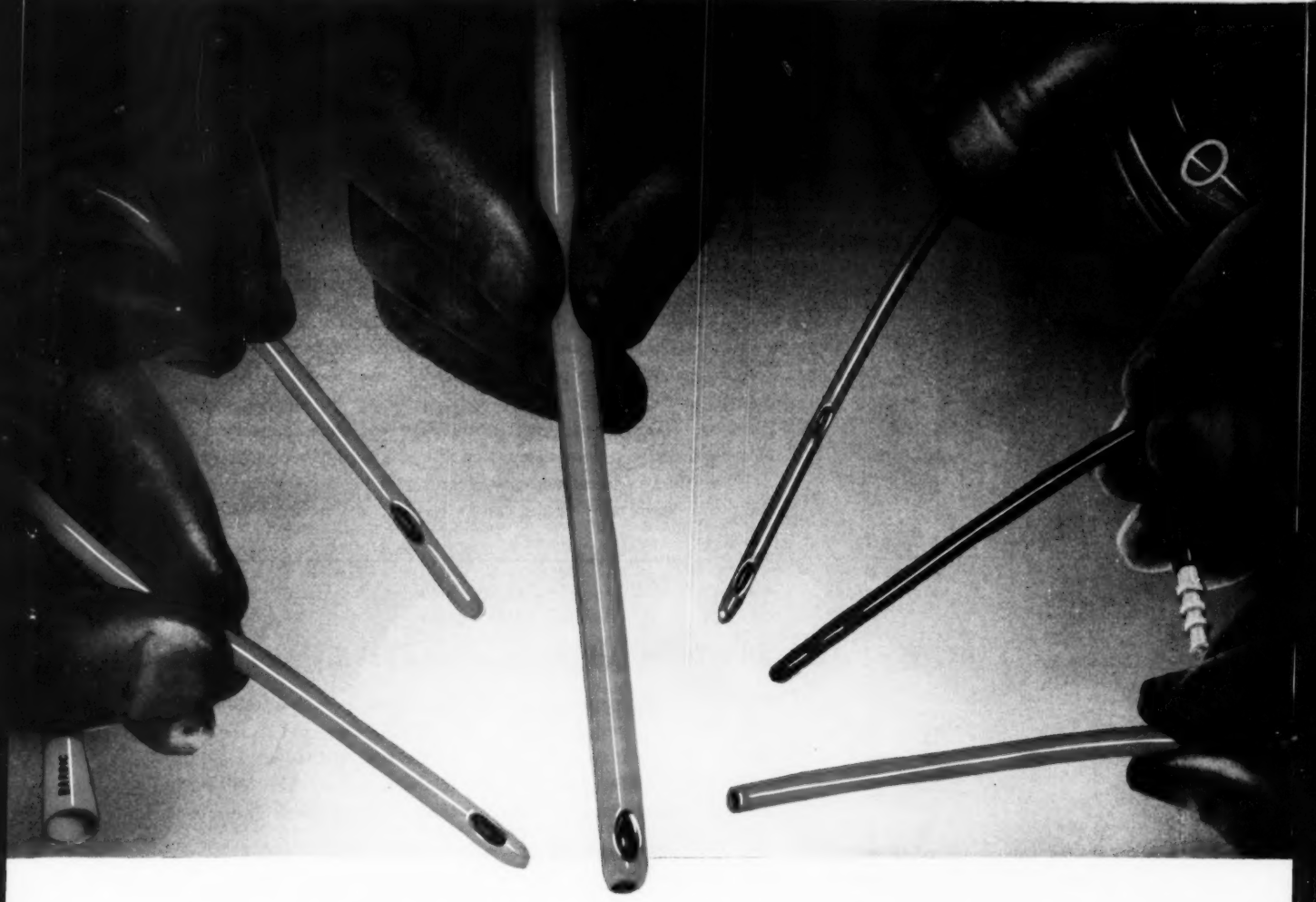

NEW! BARDIC™ Catheters and Tubes of an Entirely New Compound

New Smoothness, Strength and Long Life are an Aid to Easier Introduction, Better Fluid Flow and Lower Costs.

These new Bardic Catheters and Tubes are made of a new vinyl compound especially developed by the United States Catheter and Instrument Corp. They also are given a new heat-curing treatment at carefully controlled temperatures far higher than any encountered in autoclaving or boiling.

Here are the resulting features that make these new Bardic items unlike any others. They have a glazed, glassy smooth surface inside and out. Each has the exactly correct pliability. Lumens are large because the walls, while thin, are unusually strong and of uniform thickness throughout.

One important feature of the Bardic line is the uniformity of the funnels which are the same shape and size on all catheters and tubes irrespective of the size of the shaft. The funnel has been specifically designed to give an easy, perfect fit on a catheter tip syringe.

Clinical use has demonstrated these important advantages of the new Bardic Catheters and Tubes.

1. They are easily introduced because of their smoothness and proper pliability.

2. Fluid flow is aided by the large lumen, the inside smoothness and the large carefully formed eyes.

3. They resist collapse when suction is applied because of their unusual wall strength.

4. Cleaning and disinfecting is easy because of their glazed, non-porous surface. Cold solutions, such as Detergicide, may be used with a valuable saving in time and money.

5. Extreme tests of autoclaving and boiling have caused no marked change either in appearance or in usefulness.

Long shelf-life is assured because they will not crack or become tacky due to oxidation, heat or light.

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	PER DOZ.
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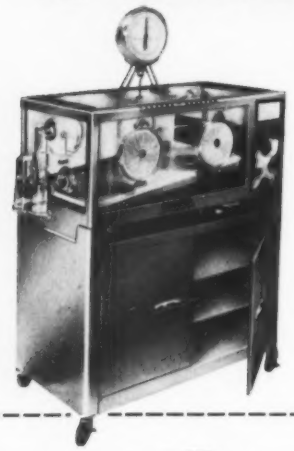
3 Great Baby Incubators



1 ARMSTRONG DELUXE H-H (Hand-Hole Type) INCUBATOR

Truly a beautiful, big, deluxe Baby Incubator—big enough for a 26″ baby. Designed and built to sell at a low price. Thick, transparent Plexiglas plate set in steel frames on all four sides. Safety glass top.* The one low price includes big 4-caster cabinet. Nebulizer, tilting bed, foam rubber mattress, oxygen control for *both* high and low concentrations. Normal humidity control. Simple design, simple operation, easy cleaning. A bigger Incubator for the larger term baby or the critically small premature baby.

2 ARMSTRONG X-P (Explosion-proof) INCUBATOR

The FIRST explosion-proof baby incubator ever built and the FIRST to be tested and approved by Underwriters' Laboratories for use wherever explosive gases create a hazardous atmosphere. SAFE in the delivery room. SAFE in the surgery. SAFE for asceptic transportation of infants from delivery room to nursery.

3 ARMSTRONG X-4 (Nursery Type) INCUBATOR

The original Armstrong baby incubator designed for safety, reliability, simplicity of operation, low operating cost and low initial cost. Experienced-perfected and hospital-proven throughout the world. The X-4 was the first Baby Incubator ever to be tested and approved by Underwriters' Laboratories and is still the low-cost Baby Incubator of choice for general nursery use.

*Scale not furnished as standard equipment since one scale will serve several incubators. Can be supplied as an accessory.

Write for complete details on any or all of these 3 Armstrong Baby Incubators.

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BACK OF EVERY ARMSTRONG BABY INCUBATOR IS OVER 20,000 INCUBATORS' WORTH OF EXPERIENCE. SINCE 1943 THE SELLING PRICE TO YOU OF THE ARMSTRONG X-4 BABY INCUBATOR HAS BEEN INCREASED LESS THAN 3½%.

wire from Washington

MEDICAL LEGISLATION ROLLS ALONG

For the first time in many, many years, medical and hospital legislation really is rolling along in Congress. Not all of it will roll through and on to the White House, but several bills are almost certain to get there. Here is the story in brief:

1. **Legislation to expand** the Hill-Burton hospital construction law is almost certain to pass in some form, despite a strong inclination in the Senate to make some drastic amendments. It would provide federal funds — in addition to the regular H-B appropriation—for construction of diagnostic and treatment centers, nursing homes, hospitals for the chronically ill, and rehabilitation facilities.

2. **The vocational rehabilitation program** will be stepped up under legislation now under consideration. The issue is somewhat muddled, and final enactment is not assured, but prospects are bright that the federal government will start spending more money on rehabilitation, while at the same time forcing states to increase their financial support for the joint program.

3. **A change is to be made** in the system of allocating public health grants to the states, but there is wide disagreement on what new system to substitute for the old. For years public health officers have complained that U.S. grants earmarked for specific diseases were too inflexible to meet varied local conditions; there are almost no defenders for the system, and it is certain to go. In its place the administration proposes substituting three forms of grants, for (a) maintaining general public health work, (b) extending and improving present programs, and (c) experimental public health programs. There is strong feeling, in Senate and House, that the first two types should be combined, allowing the state public health officers to decide how to distribute the money. Also, there is pressure to lay down some restrictions on the experimental grants, which otherwise could be made entirely at the discretion of the P.H.S. surgeon general.

4. **The Administration's plan** for federal reinsurance of voluntary health insurance services is making slow progress, and of the four bills mentioned it is regarded as least likely to succeed.

HILL-BURTON

The bill to expand the Hill-Burton program to help out health facilities that do not qualify as hospitals got through the House with little opposition, and with comparatively minor amendments. By the time the Senate subcommittee opened hearings, however, the atmosphere had changed. American Hospital Association's testimony was principally responsible for the senators' decision to look a little deeper. The A.H.A. questioned whether a complicated amendment was needed; it suggested instead that the H-B law merely be amended to qualify nursing homes and rehabilitation facilities for U.S. grants, and that chronic disease hospitals be given a high priority. Up to now, local communities have been reluctant to sponsor chronic disease hospitals, which are a heavy financial burden.

The A.H.A. idea grew in popularity, particularly after the Senate subcommittee realized that diagnostic and treatment centers would have to be more clearly defined than they were in the bill passed by the House. Under the A.H.A. formula, such centers would be eligible for grants only if they were a part of a complete hospital. It was apparent the A.H.A. had a way to simplify the legislation, to avoid a controversy over treatment and diagnostic centers, and to put the entire Hill-Burton program in one appropriations basket. The latter point was particularly appealing to the senators; it meant that appropriations for hospitals, clinics and centers could be easily moved up and down annually, depending on the economic atmosphere in the Congress and in the country.

Although this more critical attitude of the senators meant delay, it did not doom the H-B expansion bill; there is little basic opposition to the idea of spending more U.S. money for hospitals and health centers.

VOCATIONAL REHABILITATION

The House interstate and foreign commerce committee started its hearings on vocational rehabilitation only after the Senate committee's hearings were well under way. But on both sides there was a determination to get this bill enacted.

Anything to help the handicapped carries political appeal, plus humanitarian and medical interest. Supporting this legislation, in addition to the lineup of federal officials, are such influential individuals as Dr. Howard A. Rusk, and most of the associations to assist the handicapped.

The bill appeals to this Congress also because it points out one specific area where it may be possible to induce the states to relieve the federal government of financial responsibility.

Despite delays and arguments over implementation, prospects are excellent that this legislation will be enacted. Its goal is to more than triple the number of persons rehabilitated each year.

PUBLIC HEALTH GRANTS

Several basic points are involved in the argument over changing the system of public health grants. As mentioned, state public health officers generally are disgusted with the present system, under which U.S. grants for tuberculosis work, for example, can't be used for venereal disease. Yet the health officers want to be sure that the new system isn't just a trick to allow the U.S. to cut down on all grants. Mental health officers — in many states independent of the health officer — are worried that a lumping together of funds will leave the health officer in a position to starve out the mental health program. This argument was presented so convincingly that the bill was amended in the House committee to protect mental health budgets.

All public health officers are wary of the provision in the bill that would give the U.S.P.H.S. surgeon general complete authority over grants for public health research. Unless this section is changed, the surgeon general will be able to make direct allocations to institutions and individuals within a state for research, regardless of how hard-pressed the state health department is to keep up such essential work as control of communicable diseases.

The Senate committee already has decided that this power of the surgeon general should be pared down, and that the state health officers should have some say about all U.S. grants to their states.

But these differences are being compromised; as with the vocational rehabilitation bill, there is so much support behind the grants bill that it will be passed in some form. The present earmarked grants are done for.

REINSURANCE

While American Hospital Association is taking the lead in changing the Hill-Burton expansion bill, and probably will get what it wants, the association may not be so successful on reinsurance. In fact, the growing feeling on Capitol Hill is that there won't be any reinsurance bill enacted.

Of the influential national organizations, A.H.A. and the Blue Cross Commission stand almost alone in supporting the bill. They are being listened to quite carefully, however, because they would be more intimately involved with reinsurance than any other of the groups testifying.

William S. McNary, chairman of the A.H.A. Government Relations Council, testified for A.H.A. and the Blue Cross Commission at both Senate and House hearings. The testimony was substantially the same in each case. While he did not express enthusiasm for the Administration's reinsurance proposal, his endorsement was unqualified. Mr. McNary said in part:

"Some 90 million Americans have some type of hospital prepayment protection. Blue Cross alone has some 43 million persons enrolled. Coverage of the balance of the employed population and their dependents is urgently needed. This is particularly true of the low-income groups and those with special needs for hospital care. Much experimentation has been carried on by Blue Cross plans endeavoring to cover groups difficult of enrollment, such as the self-employed, farm workers, the aged, certain dependents in households, and so on.

"We do not believe that the total goal to be attained under voluntary prepayment will come easily. We do think that it can be accomplished and that this proposed legislation may help to bring it nearer."

At another point he described the reinsurance idea as "a step in the right direction to facilitate exploratory measures."

A.H.A. had several suggestions for making the plan more effective. It proposed that regulations drafted by the Secretary of Health, Education and Welfare be subject to approval by the Health Service Council, which would be set up under the act. Mr. McNary also said language in another part of the bill should be clarified so that confidential information furnished by a carrier in applying for reinsurance could not be made public without the carrier's approval. He offered an additional recommendation on publicity, in this case urging that the public be informed when a carrier has been accepted for reinsurance. The original language of the bill, he said, seems to imply that any publicity at all in this direction would be unwise.

Lining up against the bill in Senate and House hearings were representatives of various segments of the insurance industry, spokesmen for the U.S. Chamber of Commerce, a witness for the American Medical Association, and a representative of the Blue Shield Commission.

Although the testimony of these critics varied widely, the witnesses agreed in general on several points of objection:

1. Reinsurance is not necessary because it would not make uninsurable risks insurable, would not help to sell insurance and would not reduce the cost of insurance.

2. Progress of hospital and health insurance over the last few years amply demonstrates that nonprofit and commercial companies can do the job alone if not interfered with.

3. The intrusion of the federal government into this field, might, despite any safeguards, point the way to posable control over the practice of medicine.

The American Federation of Labor also appeared before committees with criticism that at points amounted to denunciation. The A.F.L.'s objection was not that the plan went too far, but that it was so "timid and faltering" that it would be useless. Under questioning by committee members, however, A.F.L.'s Nelson Cruikshank would not agree for the record that he was "opposing" the bill.

A somewhat similar position was taken by Dr. Paul Hawley, whose influence with Congress still is a factor. He thought that the bill "might not" do what the Administration was hoping it would do.

By May 1 if the reinsurance bill wasn't dead, at least it was not very much alive. A few members of the House committee were suggesting that it be voted down and forgotten for the rest of the year.

NOTES

Physicians and other self-employed persons who don't want to be covered by social security are putting pressure on committees handling the omnibus bill, but to date there is no evidence that they will succeed in getting exemption.

Selective Service has resumed its processing of physicians for possible call later in the year under the Doctor Draft. The few Priority I and II men remaining will go first and early; next will be the younger men in Priority III.

Adm. Ross T. McIntire, who has been around Washington a long, long time, may return for another tour. He is campaigning for the Democratic nomination to Congress in the 30th California district. Posts he has held: navy surgeon general, presidential physician, medical director of national Red Cross, member of scores of commissions.

A Hoover Medical Task Force committee, headed by the Rt. Rev. Donald A. McGowan of the National Catholic Welfare Conference, is looking into the possibility of using voluntary hospital and health insurance to care for various federal dependents, including veterans, service families, merchant seamen. Others on the committee: Dr. H. B. Mulholland, Manton Eddy, Jay C. Ketchum, E. A. vanSteenwyk.

With the omnibus tax revision bill passed by the House and making progress in the Senate, no objection has yet been raised to the liberalization of deductions for medical expense. The tax saving could be $25 or more for a moderate size, middle-income family with heavy medical expenses.

The House veterans affairs committee has taken the unusual step of officially recommending a moratorium on corrective legislation for the Veterans Administration. In a resolution the committee proposes that nothing be done about V.A. until the agency has had a fair chance to see the effect of its new admissions questionnaire.

The Modern Hospital
MAY 1954

LOOKING AROUND

New Journal

A NEW kind of magazine for doctors was announced the other day—a weekly digest of the clinical literature that is recorded on tape, so the busy practitioner can plug in a listening device in his car and "read" as he drives from office to hospital to patient's home.

This sort of thing makes us nervous.

Nein!

A FRIEND of ours who is something of an authority on hospital staff problems, and unquestionably knows more about the details of medical staff organization in five minutes than we do all day, has reproached us for publishing a report of the doctor-hospital dispute in Ironwood, Mich. —a situation which has turned out badly, so far, for the hospital. "Publication of the report will only make our work harder," our friend said, referring to the efforts of all of us to improve standards of medical care in hospitals.

We disagree. The view that the Ironwood report will do harm rather than good, as we see it, is based on a misconception of the intelligence and character of hospital administrators and trustees, or a misconception of the intention of doctors, or both. We think our readers are smart enough to understand and avoid the mistakes that were made at Ironwood, and courageous enough to carry on their programs of medical improvement even at some risk of controversy, and we doubt that the Michigan court's decision, now under appeal, will embolden any doctors to sue for elimination of restrictions on staff privileges, even if they wanted to.

Already there is some evidence that we are right. A number of hospital administrators have written us commenting on the report, and many have asked for copies to distribute to board and staff members—obviously agreeing with us that the lessons of the Ironwood case will be instructive. In fact, the president of the board of one hospital that was sued some time ago by a doctor who was dropped from the staff has asked us for copies of the report, believing it will help the hospital's, and not the doctor's, cause.

Even if this were not so, however—even if we were wrong and our friend were right, and the report turned out to be harmful rather than useful—we would still take the position that it should have been published. The primary function of the press, in a professional field as in society generally, is to inform. It is not our responsibility to decide, like a teacher in a classroom, what information will be good for our readers and what may be hurtful or confusing. In a free society the press owes its readers all the information it can gather and report —unfavorable as well as favorable. The editor may exercise his judgment in determining what is important, but never in determining what is good or bad for his readers. For us, failure to report the Ironwood case, once the facts were known, would be comparable to a newspaper's failure to report a military defeat on the ground that it would be harmful to public morale. Suppression of news that hurts is the mark of a controlled press in a controlled society. We want no part of such a press, or such a society. As long as we have a free press that treats its readers as adults who can take the bitter with the sweet, we shall never have a ballot that says "Vote *Ja!*"

Old Stuff

MAN is insecure under the best of circumstances in this uncertain world, and the pressures of hospital life, especially, seem to breed a virulent strain of insecurity. It is comforting, therefore, to find in this month's hospital news several items that have the nourishing quality of stability, if not antiquity. It is good to think about men and families and institutions that are unaffected by the fast currents of time and circumstance.

It is good, for example, to think about Bryce Twitty, administrator of the Hillcrest Hospital at Tulsa, Okla. Last month, Bryce Twitty signed a birth certificate for his first granddaughter—an act he had performed, twenty-five years earlier, for the baby's father, Bryce Twitty Jr.

It is good to think about Robert Bachmeyer, who was inducted last month as president of the Ohio Hospital Association, a position held some thirty years ago by his father, the late Dr. Arthur C. Bachmeyer.

It is good to think about Dr. Kenneth Babcock of Detroit's Grace Hospital, the newly appointed director of the Joint Commission on Accredita-

tion of Hospitals. Babcocks have headed Grace Hospital for forty-four years, it turns out, Dr. Kenneth Babcock having been preceded by *his* father, Dr. Warren Babcock.

It is best of all, perhaps, to think about Richard E. Schmidt, the hospital architect. When bids were opened last month on an addition to Alexian Brothers Hospital in Chicago, Mr. Schmidt was among those present. He was also on hand when bids were opened on the original hospital building, which he designed. That was fifty-nine years ago.

Felony

THE way to put an end to ghost surgery and fee splitting, according to an outspoken New York jurist, is not to leave it up to the medical profession, which has failed to do the job, or to put it up to the public in magazine articles, which are deplorable, but to have the law on the offenders. "Quit being namby-pamby about it," said Oliver K. King, former county judge who is now legal chairman of the medico-legal relations committee of the Westchester County (N.Y.) Medical Society. "Put fear of exposure, conviction and revocation of license into the offenders. The law and the machinery for its enforcement are at your hand. Use it."

Among others, Judge King holds hospital administrators responsible for ghost surgery. Any surgical procedure is assault with a deadly weapon, he points out, except for the consent of the patient. "The ghost surgeon lacks consent entirely and completely," Mr. King said in an article in the *Westchester Medical Bulletin*. "The patient has never met him, never seen him, never heard of him, and never been told that surgery is to be performed by him. Hence the attack upon the patient's body by the 'ghost' is without consent and is a criminal assault."*

Reviewing a case in which the Mother Superior of a hospital discovered a staff member doing ghost surgery and had him fired from the staff, Judge King asked: "Why in heaven's name didn't she telephone the office of the district attorney?" Expulsion from medical societies and disbarment from use of hospitals are not the answers, he added: "Thus are created by necessity private hospitals or sanitariums manned by unethical and unscrupulous doctors. Why not kick the scrubs entirely out of the profession? Revoke their licenses. . . . The question is whether or not [the accused] is guilty. If so he should pay the penalty. The greatest value to society in these matters is the deterring element. The medical profession ignores this principle, primarily because it tries to be a law unto itself. And in this capacity it has failed."

Any citizen having knowledge of a crime has the duty to report it to the district attorney and give testimony of his knowledge to the grand jury, Judge King explained. "A hospital superintendent, any doctor, nurse or orderly having knowledge of the facts may, and should, do so," he concluded. "Failure to do so, especially on the part of the executive of the hospital, would be compounding a felony."

Caveat

BROODING about the bitterness with which some medical society officials, and some hospital administrators, have been attacking the service principle of Blue Cross-Blue Shield in recent months, and defending the proposition that commercial insurance is just as good, if not better, we thought about a friend of ours whose son has been in the hospital since last December. So far, Blue Cross and Blue Shield have provided some $1500 in benefits; they are still paying a portion of the bill, and there has never been any question about continuing benefits in force.

In contrast, another friend not long ago sent us a copy of a communication he received from the company that carries his hospitalization plan. "For health insurance you must be associated with healthy people, not sick ones," this printed form said. "If your health is below par, or becomes below par, you cannot expect to continue indefinitely in the group. Furthermore, when the time arrives that you meet with an accident or your health fails, you must be prepared to accept benefits, not based entirely on your needs, but based upon your needs and limited by an amount which bears a reasonable relation to the amount of your current contributions, bearing always in mind that your contributions in previous years have been consumed in payment of claims, taxes, expenses and the accumulation of reserves for contingencies."

Easy Come

ALEXANDER P. MARAN, a cashier, or former cashier, at Manhattan State Hospital in New York, has explained how he embezzled $267,000 from the hospital in five years. It was a cinch, he told police. Being a state hospital, Manhattan has no fixed rates; patients pay what they can, and for five years Alexander took in $1000 a week more than he reported. When he found out state auditors were coming to check his accounts, Alexander got scared and ran away. Later, he came back and gave himself up. Obedient to the rigid conventions of embezzlement, he had spent the money on high living and betting on the horses.

Man's World

DURING a visit to the office not long ago, our friend Anastasia commented on a piece we printed recently about a West Coast hospital that hired an artist to do a modern, abstract mural for the labor room.

"Pretty interesting idea," Anastasia said. "Wonder how artist went about it?"

We looked around in the file and came across a statement the artist had written. "I have tried to create an atmosphere where women in labor will be transported into a world of vision where their pain and anxiety are minimized," this said, "an ever-changing world without beginning or end. Surely there is a great similarity between the birth of a baby and the creation of a painting."

Anastasia looked pained. "What's artist's name?" she asked.

"Gordon F——" we started to answer, but Anastasia interrupted us.

"I knew it!" she said, and walked out.

*King, Oliver K.: Combating Ghost Surgery, Westchester Medical Bulletin 22:3 (March) 1954.

ALBERT W. SNOKE, M.D.

ADMINISTRATOR SAYS:

Emotion, Economics and Ethics Are All Tangled Up

PHYSICIAN SAYS:

Hospitals Are Invading Medicine's Territory

WALTER B. MARTIN, M.D.

A physician and an administrator present

Both Sides of the Hospital-Doctor Dispute

EMOTION, ECONOMICS AND ETHICS ARE ALL TANGLED UP

ALBERT W. SNOKE, M.D.
Administrator, Grace-New Haven Hospital, New Haven, Conn.

ALTHOUGH the problems between hospitals and physicians apparently have become more prominent over the past few years, I suppose that one can trace the seeds of fundamental conflict back many, many years. As medical care has grown in complexity, so has the hospital, and it is becoming more and more the center of health activities in the community. Patients today are coming to the hospital for ambulatory diagnostic procedures, because so many of these new procedures are expensive and complicated and it has been found that it is much more economical and efficient to have them concentrated in the hospital area than it is to duplicate them expensively throughout the community. Consequently, preventive medicine, diagnostic facilities, and ambulatory care are becoming additional facets to the modern hospital.

Along with this expansion of the area of influence in the hospital has grown the rôle of the members of the hospital board of trustees. The vast majority of good voluntary hospitals of this country are governed by boards of trustees made up primarily of laymen elected as civic-minded citizens representing a broad cross section of the community. The lay member of the hospital board today is an important component in our health care organization and is becoming much more sophisticated and knowledgeable over his responsibilities and rôle in the operation of the hospital. He realizes that his responsibility does not end with the provision that the hospital operates in the black rather than the red, or that the food is palatable, or that the janitorial staff is efficient. The modern board member realizes that he has also a moral and legal responsibility to see that proper medical care exists in the hospital, and that while he himself is not capable of providing or directing this medical care, he, as a member of the board of trustees of the hospital, must assure himself that the professional staff is living up to proper standards.

It is also significant that certain medical specialties such as pathology, radiology, anesthesiology and physical medicine are peculiarly adapted to hospital practice and have developed with full-time salaried specialists in charge in many hospitals. This has caused some members of the medical profession to look at hospitals as large laymen-dominated corporations which are in the business of providing medical and hospital services, and which are going to tell the doctor how and when and where he should practice medicine and force him to comply to arbitrary regulations through salary-check control.

It is my belief that this is the underlying basis for the tremendous amount of adrenalin that has been secreted over the last 20 years, and the inordinate amount of paper and ink expended in drafting and redrafting resolutions

These articles are condensed from papers presented to the New York County Medical Society and published in New York Medicine, March 20.

that have been presented, re-presented, amended and re-amended by so many different organizations.

It was because of the Hess Report in 1950 in its several variations, the later Hess-Askey Report, and the various interpretations that were placed upon them by organized medical groups and individuals, that the American Medical Association and the American Hospital Association agreed in June 1951 to have a joint committee at the board of trustees level to review this entire situation. On this committee were the president of the American Medical Association, the president-elect, the chairman of the board of trustees, and three other members of the board of trustees of the American Medical Association, as well as the immediate past president of the American Hospital Association, the president-elect, and the members of the board of trustees of the American Hospital Association.

As far as I am concerned, it was one of the most stimulating and pleasant experiences that I have had. It was the first time that the leaders of the hospitals and the medical profession sat around the table in a friendly give-and-take atmosphere to review common problems calmly and dispassionately. It was an opportunity to develop mutual understanding of the problems faced by each other, and I don't believe that I exaggerate in saying that there was mutual education. The "Statement of Principles of Relationships Between Physicians and Hospitals" was a result of this series of meetings, and this was subequently endorsed by both the board of trustees and the house of delegates of both A.M.A. and A.H.A. this past year. An approach also was made to the Judicial Council of the American Medical Association, and a clear and positive statement of the rôle of the salaried physician in regard to ethics was presented last December.

When the A.M.A.-A.H.A. joint committee first met, the primary subject on the agenda was the rôle of the salaried physician, his relationship to the medical profession, to his specialty boards, and to the hospital, and whether or not he was "ethical" according to the Code of Ethics of the American Medical Association. It was quickly realized, however, that this was only part of the problem of hospital-physician relationships, and the joint committee very properly outlined a number of points at issue, and the statement went on beyond the single problem of the ethics of the salaried physician. Reference was made to the necessity of close relationship between the medical staff and the governing board of the hospital, and the need for mutual understanding. Agreement was reached that the financial relationships between physician and hospitals should be developed at the local level, based upon local conditions and needs, and with no exploitation of physicians, hospital or patient.

There must be an understanding, cooperative and trusting relationship between the doctor, the trustee and the hospital administrator. This cannot be established by fiat or edict, but only through close acquaintanceship and association. Each has to realize the responsibility and the place in the hospital organization of the other.

The hospital trustee is responsible to the community for the over-all operation of the hospital. This means not only the fiscal and hotel aspect of the institution, but the medical care as well. The hospital trustee is the representative of the community—particularly when the community comes into the hospital as a patient. The hospital trustee is liable

HOSPITALS ARE INVADING MEDICINE'S TERRITORY

WALTER B. MARTIN, M.D.

President-Elect, American Medical Association, Norfolk, Va.

THE last 30 years have seen a great expansion of hospitals and of the facilities for the care of the sick. This rapid expansion of hospitals has followed the great advances in medicine during that time and the application of new procedures to the prevention and control of disease. Hospitals have become larger and their operations more complex. The cost of providing hospital service has increased until now their financial integrity is often threatened.

The mounting cost of hospital care has brought about widespread criticism and the conviction has grown that the pay patient should not be burdened with a super tax to meet the cost of the low or the nonpay group. In an effort to meet public criticism, the hospitals have endeavored to keep their room charges down and have looked to the special services as a source of income that would bridge the gap.

Physicians are primarily preoccupied with the care of their patients. They need and demand all of the diagnostic and therapeutic services that a good hospital is capable of furnishing. Their thinking, however, has not kept pace with the problem of providing and financing these services. As a result of these and other factors, differences have developed between the administrators and the boards on the one hand and the professional staff on the other. Hospital boards in general are made up of individuals, prominent in their community, who are interested in community welfare, and who can bring strength and support to the hospital. Often their knowledge of the components of good medicine is limited and particularly in reference to its technical aspects. It is necessary for the trustees to have frequent contacts with the hospital administrator and to seek his advice on many matters. Their information and knowledge of the problems of medicine is often limited to what they have gained from their personal physicians or from casual contacts. Too often there is no direct exchange of ideas between the board and the professional staff. The administrator may be the sole go-between. Through no fault of his own, the administrator may have undue influence on the thinking of the board members, even in medical matters.

The physician on the other hand is often poorly informed of, or quite insensible to, the problems of hospital financing. He gives little consideration to the matter of conserving hospital resources or at times to the total cost of the services to his patient and to the community. He can control to a considerable degree certain of the

legally and morally for the care of the patients, and there is no way that he can avoid this final responsibility.

The hospital administrator is the agent employed by the board of trustees to see that the hospital in its entirety is properly run. The doctor is the individual who actually provides the medical care and sets the standards of professional operation. He has technical and professional knowledge, and the life and well-being of the patients under his care are his direct responsibility. However, the physician must operate under the basic rules and regulations set forth by the board of trustees of the hospital as required by the charter and by-laws of the hospital. How are these rules and regulations established? They are developed by the medical staff under certain broad policies set forth by the board of trustees, the guiding philosophy of which is the best possible hospital and medical care for the patient. The board of trustees delegates its responsibility for the care of the patients to the medical staff and then gives it the necessary authority to carry out this responsibility.

It is obvious that any such relationship is dependent upon mutual understanding and clear lines of communication. Here is where hospitals and physicians have run aground in the past in bitter arguments as to whether doctors should be on the board of trustees or not. I think this is a far less important issue than how the staff and the board can have mutual contact and understanding. My own opinion is that there is more potential danger in having practicing physicians on the board of trustees of a voluntary hospital than there is in excluding them. The proper type of practicing physician can be of value to a board of trustees. However, an improper selection may provide a self-seeking individual who would have an unfair advantage over his colleagues and who could exert undue influence on the board. I am convinced that all of the advantages of the physician on the board of trustees can be obtained by a joint conference committee between the board and the medical staff and will avoid the disadvantages that can occur and have occurred as a result of having members of the medical staff on the board itself.

If the medical staff men can realize that their membership on the hospital staff is a privilege rather than a right, and that the board of trustees and its hired agent, the administrator, are concerned with the proper running of the hospital so that the patient can get the best possible care, and that decisions regarding professional care must be developed by the medical staff itself, and finally, that there must be free and easy communication among the several groups, most if not all, of our problems will disappear.

Control of medical practice by hospitals is an issue that has had far more attention paid it than is justified by the facts and circumstances. A lay board of hospital trustees or a hospital administrator is not telling the doctor when to operate, what medicine to prescribe, and how to care for the patient. But the hospital does have a substantial rôle in the control of medical practices carried out in the institution. It is my belief that one of the most significant forces for the improvement of medical care in this country is this control of medical practice by the hospital.

Let us be realistic. What have you doctors as individuals done in the last 20 years when you have heard or observed a professional colleague practicing poor or improper medicine? What has this medical society done officially about

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factors affecting the cost by cooperation with the administration. Important items are: the time of admission and discharge, prompt attention to examination of the patient, and the recording of orders. He should give careful thought to the number and extent of laboratory and other diagnostic procedures ordered and to the choice of the drugs administered. This is not only good medical practice, but will be reflected in less expense to the patient, better operating efficiency in the hospital, and less total cost to the community. Correct diagnosis and appropriate treatment rest primarily on a good history and a careful physical examination. The auxiliary procedures should be pin-pointed to prove or disprove a presumptive diagnosis or diagnoses. Too often the physician is not clear in his own mind as to the chain of events that follows the abuse of hospital services such as prolongation of stay and unnecessary use of the procedures and facilities. The results are an increase in operating costs, higher hospital charges, and larger insurance premiums for everyone who purchases insurance against the cost of hospitalized illness. The alternative to increasing the hospital charge is a lowering of the quality of service rendered by the hospitals, which eventually will affect adversely all of the patients in the institution.

A closer liaison between the staff, the administrator and the board will establish on the part of the staff a better understanding of the problems of financing and administration.

The staff also has the responsibility of developing and maintaining high professional, moral and ethical standards. Through the proper committees on each service, the professional capabilities of the staff members should be evaluated. There should be a continuing evaluation for the purpose of assuring that all patients receive a high quality of professional care.

Through a records committee, all members of the staff should be stimulated to maintain adequate and informative records, not only for their educational and scientific value, but as specific evidence of the quality of care that the patient receives. The more experienced members of the staff have the responsibility of guiding and directing policies and practices along lines that will promote the best interests of the hospital and the patient.

When the staff fails in performance of these duties, the administrator or the board may feel called upon to take over some of the professional prerogatives of the staff. This is always unfortunate and can only lead to serious dissension. It is obvious that in a learned and highly technical profession, the professional qualifications of a member can be justly appraised only by other members of that profession. For this reason the obligation faithfully to carry out our responsibility as physicians is heavy upon all of us.

The principal disturbing factor between physicians and hospitals is in the field of those divisions of medicine which are customarily carried on by full-time physicians in a hospital. In earlier days these special services presented no major problems. With the great extension of pathology, clinical laboratory and x-ray services, and the development of anesthesiology and physical medicine, the problem has become more acute. It has been further aggravated by the trend in certain hospitals to organize

DR. SNOKE:

the individual doctor who is not particularly competent or who is abusing his skill? Little or nothing. This is no criticism of doctors as individuals or of the county society. You are just not organized — nor do you have the authority or the power to discipline your associates unless they do gross harm or break the laws. No physician wants to be his brother's keeper, and an organized medical society must admit the duly licensed practitioner unless there are good reasons to exclude him. But the hospital is different. The use of a hospital by a doctor is not a right but a privilege. Rules and regulations can be established and the physician obeys them or he does not practice in that hospital. Surgery can be limited to the trained specialist (and even he cannot use his skill indiscriminately), not the untrained man with only the limitation of his conscience or the gullibility of his patient. In other words, the hospital can establish standards of medical practice and can enforce them.

If we accept a control or a limitation of medical practice in a hospital, our questions then are, how does the hospital control this medical practice, and is this practice bad for the physician and the patient? The board of trustees selects the most capable and competent practitioners in the hospital and gives them the responsibility for the supervision and control of medical practice in the hospital, and then backs them up with the authority to see that the broad policy of "best care for the patient" is properly carried out.

In other words, doctors control the practice of medicine in a hospital — but they do it through the authority delegated to them by the governing board of the hospital and do it far better than if a *laissez faire* attitude were to exist. From my own experience and observation, I have repeatedly been impressed with the conscientious, judicial and thoughtful attitude of physicians appointed by the hospital board to positions of responsibility for medical staff activities.

Salaried physicians and ethics is another area in which the battle of resolutions has been waged ad nauseam: The fundamental issue is whether a physician may be employed by a hospital on a salary and the hospital be allowed to bill and collect for the professional services of that physician. Unfortunately, prejudice and emotion, economics and ethics have become inextricably mixed, and one is never sure which factor is being considered when one gets into the argument.

The position that a salaried physician in a hospital is automatically unethical has now been completely exploded. The Judicial Council of the A.M.A. has recently spelled this out in as clear and concise language as one could wish.

In the last report of the Judicial Council to the house of delegates of the American Medical Association, the following excerpts are of interest:

"The Council has repeatedly stated that the acceptance of a salary does not in itself constitute unethical conduct." . . . "The issue to be resolved then is factual. If, in a given situation, a physician disposes of his professional services under terms which permit exploitation, his conduct is unethical. Knowledge of the facts, however, may reveal that there is no exploitation; that there is not an unethical division of fees; that there is not a denial of free choice of physician as defined by the Principles or that the arrange-

DR. MARTIN:

other departments on a full-time basis with the physician on a salary and with the patient's fee being collected by the hospital.

Whether this movement is inspired by the purpose of adding to the income of the hospital or by purely humanitarian considerations, it has the effect of putting the hospitals into the practice of medicine, and bringing them into competition with physicians who practice in the several branches of medicine. Under certain conditions and to a limited extent, this may be necessary and justifiable, but as an operating principle, most of us feel that it will not in the end be productive of the best quality of medical care. When the profit motive enters into a plan and it is extended into the operation of outpatient departments by a full-time staff and at a "realistic fee" our concern becomes deeper.

The further invasion of the practice of medicine occurs when a hospital on a fee basis sets up a home service program operated by a full-time hospital staff. We believe that the concept of the individual physician being responsible for an individual patient is still a sound one and that in the corporate practice of medicine this relationship is damaged or destroyed. The gradual intrusion of hospitals into the field of medical practice, and the highly vocal demands of some that it be further extended, has pointed up more sharply the situation in reference to the special professional services within the hospitals.

The hospital is also extended in another direction, that is, in the exercise of authority or power on the part of the administrator and the board in professional fields. The lack of contact between the professional staff and the board is largely responsible for this. A hospital and its staff are properly engaged in a cooperative enterprise, the purpose of which is to provide a patient with the best medical care possible with the funds available. As in all cooperative endeavors, there must be a clear understanding of the prerogatives, powers, and responsibilities of both parties, and a mutual respect for each other. To that end there must be a free flow of information and ideas between the staff, administration and governing board.

The American Medical Association and the American Hospital Association in their discussions recognized that local conditions vary widely and that no single rigid plan can be formulated to accomplish this purpose, but noted four suggested methods of bringing this about. This joint committee agreed on certain other principles, which I believe are worthy of quoting:

1. That professional evaluation of chiefs of service and members of the medical staff should be the responsibility of the medical profession. The method of selecting these individuals must be subject to local arrangements and local conditions. In any such arrangements, however, the principle of the freedom of the staff to make recommendations, subject to approval of the hospital governing board, should be recognized.

2. The medical profession and the hospitals recognize that certain special services, such as anesthesiology, pathology, radiology and physical medicine, are integral parts of the practice of medicine and of the services necessary for hospital patients. Physicians in these fields should have the pro-

ment does not cause a deterioration of the quality of the medical service."

There is, unfortunately, a militant minority that still disagrees and this is its privilege. However, these individuals or groups do not help promote understanding between hospitals and physicians when they confuse economics with ethics and impose professional sanctions upon the young physician who wishes to be on a salaried arrangement that he and the hospital regard as equitable. Dr. Chester Keefer recently was quoted as saying that the Code of Ethics is for the general public and not for the protection of individual doctors or groups. (J.A.M.A., Feb. 13, 1954)

The restrictions placed by the American Board of Anesthesiology on qualified physicians requesting examination for certification but who are on salary have been criticized by the Council on Medical Education and Hospitals of the A.M.A. and the board of regents of the American College of Surgeons. The specialty board required all applicants to be members of the American Society of Anesthesiologists and this professional group, in turn, required prospective members to belong to their local or state anesthesia group. These local organizations — as is presently the case in Connecticut — refused membership to any new individual on salary in a hospital. Thus, by laboriously tracing upward through the labyrinth of organizations, it develops that a competent, well trained young anesthetist has been refused an opportunity of being certified in his chosen professional specialty solely because he elects to be on a salary.

Fortunately, this restriction by the American Board of Anesthesiologists was removed last fall, but their colleagues in the American Society of Anesthesiologists still persist in disputing this issue. The January 1954 report of the American Society of Anesthesiologists on professional relations, policies and ideals again concludes:

"There simply can be no ethical basis under which a physician can permit a lay agency to sell his services for a fee without this act being a term or condition tending toward exploitation of the patient."

I am sorry — but I feel this to be nonsense. I will concede that any arrangement can be twisted so that the patient or the physician is exploited — even fee-for-service — but if we look at the type of practice carried out by physicians in full-time salaried practice, the argument that there is poor medicine or poor patient care if the doctor is on salary collapses of its own weight.

I have tried to emphasize that many of the problems and misunderstandings between physicians and hospitals could be cleared up if we were all to realize that we serve a common master and have a common goal. However, I seriously question whether we can accomplish this by forums or by papers written in hospital and medical journals. This understanding must go back to the education of the medical student and the intern and resident staff.

You physicians have a challenge to understand and support your hospitals. Learn to know the time, energy and frustration expended by hospital trustees, administrators and personnel to make the hospital a better place for the patients and you. Realize that this is a true partnership and that there are obligations on both sides. Realize that hospitals are not trying to dictate to you—rather they are trying to create the best possible environment for you and your patients.

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fessional status of other members of the medical staff. Chiefs in these specialties must assume also administrative responsibility and relationships customarily associated with such positions.

3. The right of the individual to develop the terms of his services on the basis of local conditions and needs is recognized, but such contractual arrangements should, in all cases, ensure a policy of providing professional incentives for the physician and the progressive development of the hospital departments involved, in order that increasingly improved services to patients may be rendered. Moreover, a physician shall not dispose of his professional attainment or services to any hospital, lay body, organization, group or individuals, by whatever name called, or however organized, under terms or conditions which permit exploitation of the patient, the hospital or the physician.

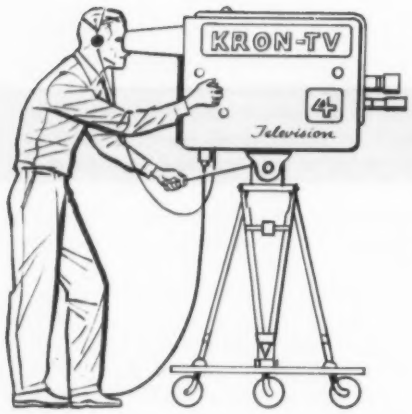
4. The chief of a hospital department may have access to financial information regarding his department.

5. It is desirable that means should be provided at local, state and national levels for review of problems of individual hospital-physician relationship by medical and hospital groups.

The recommendations made under points 2, 3 and 4, if properly implemented, are capable of eliminating much of the disagreement between the special services and the hospital. The hospital should receive adequate return on investment in equipment, including a suitable annual amount to amortize its capital expenditures. It should also be paid a fair amount for rent and all services rendered the department. The department should have full responsibility in all operational matters and free access to financial information in respect to the department. Both the department and the hospital profit indirectly by their association. The hospital with an outstanding special service attracts patients on that account, while the department gains many patients by reason of the association with a good hospital. The interest of the patient is served when the hospital and a special service department working in harmony provide a high quality of service at a charge commensurate with the service rendered and the ability of the patient to pay.

It is believed that the last recommendation can be carried out in any areas where major differences arise. It seems reasonable that an arbitration committee consisting of representatives from the administrative body of the hospital and the local county medical society with the addition of a neutral nonhospital and nonmedical representative should be set up to judge the merits of the particular problem in all of its aspects. If agreement cannot be reached on a local level, appeal should be made to a similar body at the state level. I believe, in most instances, these controversies can be settled without the necessity of appeal to a higher body.

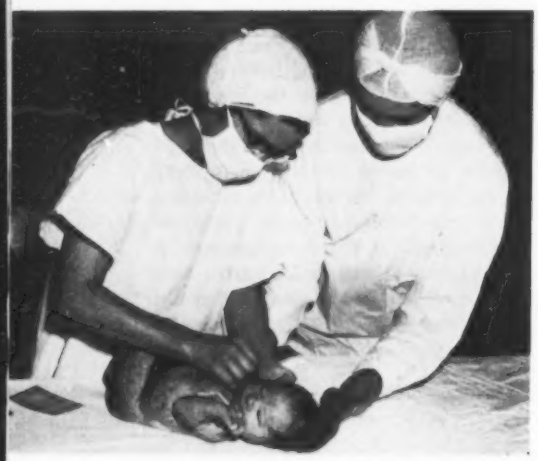
The changing pattern in medicine, the growth of hospitals, and the increasing problem of financing hospital costs have brought many new problems before us. Both physicians and hospitals have as their primary objective the provision of good medical care to all those that need it. We are mutually dependent upon each other. I believe that within the framework of our mutual interests, we can, with patience and forbearance, solve these problems.



California Hospitals Use TV to Tell the Hospital Story

A LIFE IN YOUR HANDS

MARY WILLIAMS
Director of Publicity
Children's Hospital of the East Bay, Oakland, Calif.



The youngest television performer was only minutes old. His birth was part of the program on hospital obstetrics.

Above: Jay Jacobus, program host, and Brig. Gen. James O. Gillespie, commanding general of Letterman General Hospital, run through a script with wounded soldiers. Right: "Blood Will Tell" offered a report on a laboratory.

BY USING a formula compounded of friends, hard work and ingenuity, the California Hospital Association has a successful television series on the air despite budget limitations.

The program, "A Life in Your Hands," takes the viewers behind the scenes in modern hospitals and enables them to see how the hospital laboratory works, how the kitchen and food services are organized, how the hospital keeps abreast of the latest improvements in equipment and technics in surgery and in the nursery.

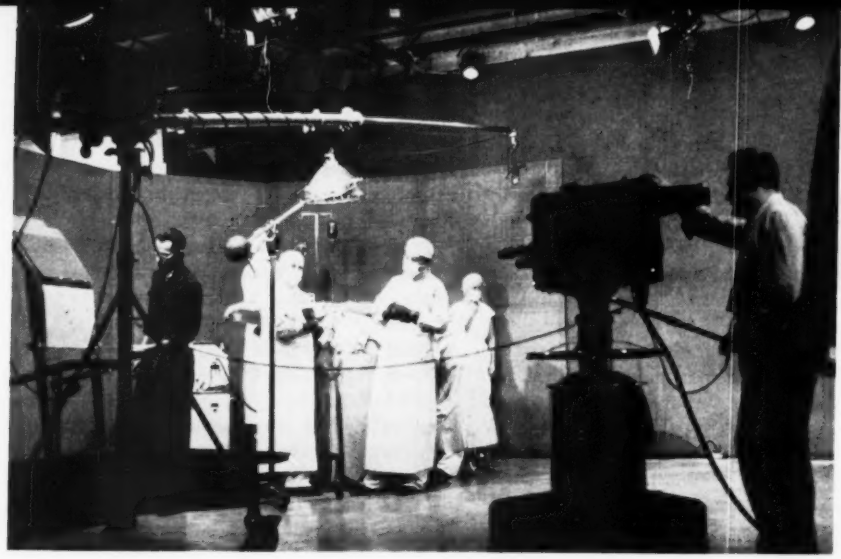
"The quickest way to turn critics of hospitals into boosters is to get them into the hospital where you can show them how hospital dollars are spent," explains Richard Highsmith, chairman of the council on public education of the California Hospital Association. "We try to do this on Hospital Day and on other special occasions, but I doubt if we get many of the severe critics to come in. But, by putting together an attractive television program, we succeed in bringing the hospital into their homes. The trick is to make the show so good they will want to turn the set on."

That the program is measuring up we know from reviews of television columnists. Terrance O'Flaherty writes in the *San Francisco Chronicle*: "If television did nothing more than produce programs of this nature, it has earned its place in our world."

Dwight Newton wrote this in the *Examiner*: "Progressively, and with progressive showmanship improvement, it (A Life in Your Hands) has taken us behind the scenes to report on premature babies, plastic surgery, nurses, heart repair and childbirth. . . . Praise must go to TV Director Bob Glassburn, Writer-Producer Lawrence A. Williams, who prepares his scripts with unusual skill, and to Announcer Jay Jacobus, who on this show proves himself as a top flight television personality."

How does a state association go about producing a television show? According to Mr. Highsmith, you start laying your plans in a wide-eyed, innocent optimism. Months later the innocence and the bright hope are a bit tarnished, but you're in it up to your neck, so you keep trying. Then, if your committee sticks with you, if you get the right station, producer, writer, M.C., director and time, you may get a glow of satisfaction from a show well done. But this comes only after you sweat through the rehearsals and suffer through the muffed lines and miscues.

The California Hospital Association is fortunate in having officers who are



Left: Surgery team from the University of California Hospital pauses during a program in which a brain tumor operation was simulated.

fully aware of the need of improving hospital public relations. George Badenhausen, of Long Beach, was president when the council on public education submitted its proposal for a television program. He and his board encouraged the project. Thomas Langdon of San Francisco, the present president, considers hospital public relations "his baby." He has crusaded tirelessly for better ways of reaching the public.

Even with this support, however, there was little money in the budget when Mr. Highsmith called in Lawrence A. Williams to help draw up the television plans. Mr. Williams combines hospital public relations with television writing and producing. He outlined the "Life in Your Hands" documentary series and an alternative dramatic series. He proposed that an acceptable commercial sponsor be obtained to foot the bill.

This sounded good to everyone. Now, well over a year later, it still sounds good. Over a period of months during which Mr. Williams called on prospects in Chicago, Los Angeles and San Francisco, some sponsors expressed interest, some TV stations expressed interest, some program package houses offered to take over, produce and market the show. But nowhere was there an offer of enough money to put on the program without surrendering too much control.

In late summer of 1953, KRON-TV Channel 4 in San Francisco, the NBC outlet in that area, offered a half-hour on alternate Sunday afternoons to the association for "A Life in Your Hands."

The council, with telephoned approval from the board, set about raising $6000 to cover at least six shows. The programs would be produced live on KRON-TV, but kinescopes—16 mm. films—would be made of each program for showing in other cities.

"The Story of Lillian" showed how occupational, physical and speech therapy helped Lillian DuBose to walk and talk again and to use her hands after an automobile accident had left her paralyzed and unable to talk. Here, she gets a lesson in speech from Mrs. Pat Jampolsky, therapist.

With only a little money it its budget, the council appealed to Western Hospital Association, Blue Cross of California, Blue Cross of Southern California, the San Francisco Hospital Conference, the East Bay Hospital Conference, the Hospital Conference of Southern California, South San Joaquin Valley Hospital Conference and the San Diego Hospital Council. All of these organizations contributed.

The first program, "Tiniest Humans, a Report on a Premature Infant Nursery," was aired on October 4. The format of that first program has been followed in later productions. The studio set was constructed to resemble a nursery, an examination room, and an administrator's office. Dr. Pauline Stitt, pediatrician now lecturing at Harvard University but recently associated with the University of California and Children's Hospital of the East Bay, was the guest doctor. The story of the preemies—their medical and hospital care—was illustrated by films and by a live baby, a 5½ pound graduate from a preemie nursery. Alfred Maffly, administrator of Herrick Hospital, Berkeley, discussed hospital costs in a three-minute scene. The program closed with the introduction of preemie alumni: 2 year old twins, and a family of preemies, a mother and three children.

Program No. 2 presented Dr. George Warren Pierce, former president of the American Society of Plastic Surgeons.

Here in a surgery room set, a cleft palate operation was simulated. This was so successful that the operating room has been featured in several other programs: one on "Heart Repair" with Dr. John J. Sampson, vice president of the American Heart Association; in "Blood Will Tell," a report of the hospital laboratory with Dr. Paul Michael, pathologist; "Foreign Bodies," where Dr. Chester Weseman bronchoscoped a child; "Brain Surgery" with Dr. Howard C. Naffziger, president of the American Surgical Society, former president of the American College of Surgeons, and "The Eyes Have It," with Dr. A. Edward Maumenee, chief of eye surgery at Stanford University Hospital.

"Surgery is very useful in adding interest and suspense to our programs," says Mr. Highsmith. "It is this added interest we need to win an audience."

The hospital message is implicit in the presentation of the trained personnel and the expensive equipment used on the programs for patient care. It is more direct in the interview which is a part of each program. In these three-minute discussions, for example, Orville Booth, president of Western Hospital Association, talked about the opportunities for nursing careers. Philo Nelson, president of Hospital Service of California, sketched the history and progress of prepaid hospitalization plans. George Collins, chairman of the East Bay Hospital Conference, told about organization and costs of hospital food services.

To make the programs suitable for showing in other cities, local references have been eliminated as far as possible. A different hospital is invited to supply the talent (nurses, technicians, resident doctors) and equipment needed for each program. These hospitals are identified in local publicity in the San Francisco area, but are not mentioned in the programs. The hospital the TV viewer sees is identified as "your hospital" or "our hospital." The single exception to this was in "After the Battle," a report on the care given wounded soldiers at Letterman Army Hospital.

About the time Program No. 6 was coming up the council decided to extend the series. By borrowing film and equipment and by keeping set and art costs to a minimum, Mr. Williams had been saving about $300 a program from the $1000 estimated. This tided the program series over into the new budget year when the board approved an increase allocation to the council on public education large enough to cover the completion of a series of 15 programs.

This will allow the elimination of the two poorest programs from the schedule of 13 which are circulated to television stations in other cities.

Unbiased observers agree that, although the programs are interesting, there have been some rough spots. Doctors and nurses are not all natural-born actors. And in the first programs of the series, there were production flaws.

Program No. 3, "Probies and R.N.'s," had a capping ceremony with a large group of students holding Florence Nightingale lamps. When The Student stepped forward to be capped, her cap fell off. Mrs. Laurel Hoffman, R.N., educational director, caught the cap and replaced it. But when The Student stepped back into line and began repeating the Pledge, the cap fell off again. Then, as if that weren't enough, one of the two television cameras caught on a cable and tipped over. Such incidents, fortunately, have been few. When they do occur—when the doctor forgets a line or when a camera is slow in setting up a shot—then the program "host," Jay Jacobus, comes to the rescue.

Jay is a lawyer with extensive experience as a radio and television announcer and sportscaster. He is never at a loss for words. He is the one professional actor who appears in the programs. The doctors, patients and other hospital personnel appear under a waiver from AFTRA, the television artists' union. Jacobus speaks with such authority that fan mail is often addressed to "Doctor" Jacobus.

His work in "A Life in Your Hands" has established Mr. Jacobus as one of the outstanding television performers in San Francisco. As the kinescopes have only recently started to circulate in other cities, it is too early to appraise his reception in other areas.

At this writing, with Program No. 13 coming up on KRON-TV, the series is running on KMJ-TV Fresno, and stations in Los Angeles, Chico, San Diego, Salinas and Eureka have inquired about the possibility of scheduling "A Life in Your Hands." Inquiries, too, have come from large cities in other states.

"We'd like to see these kinescopes used where they will do the most good," says Mr. Highsmith. "There are a number of complications which have slowed us down in our plans for these films. AFTRA rules forbid unlimited use of kinescopes. We are trying to work out a distribution system which will permit the use of the series in other states."

All that is needed to forward these plans is more money in the form of a sponsor or of donations. In the meantime, the programs are telling the hospital story throughout California.

Laurel Hoffman, educational director, and student nurses rehearsing a scene in "Probies and R.N.'s."

The Ten Commandments in

Personnel Administration

1 **Thou shalt distinguish between occasions and trends**

2 **Thou shalt not reprimand another whilst thou art mad, else that other and thou thyself become madder and reason be lost in the struggle**

3 **Thou shalt present a kindly aspect to all other fellow employes**

4 **Thou shalt give no special privilege to one whom thou likest that thou wilt not give to all, whether thou likest them or not**

5 **Thou must be the last one to lose thy head in an emergency**

6 **Thou shalt stop, look and listen to suggestions**

7 **Thou wilt show thy wisdom by acting as a mental wastebasket, if necessary**

8 **Thou shalt "Let George do it" for thus only may he show that he can**

9 **When thou makest a decision seest thou to it that it is based on investigated facts and accumulated evidence**

10 **Thou shalt acknowledge that time is the most expensive item in thy budget**

HAROLD A. ZEALLEY
Administrator, Elyria Memorial Hospital, Elyria, Ohio

IT IS with some trepidation that any administrator approaches the subject of personnel administration unless acknowledgment is sincerely made that here is one administrator who has found there are at least 10 "commandments" which, when broken, have led to some serious problems. Like any other list of commandments, it may be incomplete, it may not apply to everyone; but, on the other hand, these commandments have been hewn out of the rough rock of personal experience, and have some validity.

1. Thou shalt distinguish between occasions and trends.

It is part of human frailty that most of us slip in some way from the high pinnacle of our better selves. Even hospital administrators have been known to do this. That most of us recover is a tribute to the climbing instincts with which we have been endowed. Or, putting it another way, perhaps we would not even hire ourselves if we operated on the lowest level of our efficiency or ideals. We should therefore learn that there is a great difference between an occurrence and a standard of work or principle. Perhaps one of the finest things we can learn from the field of professional social work is that the goal of watching trends, and not occasions, is constantly before us.

We have learned to remember that unless emergency is involved, or there is danger to life and property, an occasional infraction of rules or procedures is neither the principle nor the policy of the employe involved.

2. Thou shalt not reprimand another whilst thou art mad, else that other and thou thyself become madder and reason be lost in the struggle.

The mental catharsis of "letting off steam" is not questioned. But we have learned that when, in close company, two are letting off steam together, then the pressure becomes too much, and reason, poise and balance are blown through the window. Among the many privileges still accorded to Americans is that of "getting mad." We should learn to find nondamaging places and friendly people upon whom to loose our exasperations and frustrations.

Again, unless an emergency is involved, when someone comes to the administrator and "blows his top," it is the best of wisdom to allow such a thing to happen. But it should not affect the administrator, for at least he, being the top man himself, should have his personality so adjusted that he can take greater pressure than anyone else, without having to let go at an inopportune moment. Especially is this precept true in reprimanding or firing an employe. Too many employes are fired by reason of the exasperation they produce in the mind of the department head, rather than for any true and unbiased appraisal of their worth by that department head in his more balanced moments.

3. Thou shalt present a kindly aspect to all other fellow employes.

There is a vast gulf between someone who goes around with a permanent grin and the individual who only sees as far as his own nose—and that sourly. Midway between these two is

the person who lights up in recognition of others working in the same institution, is receptive to their friendly glances, is ready to stop occasionally and listen to a purely personal matter. We recognize that the bounding optimist, who has no aches or pains, or worries at home, and who feels that the hospital operation is perfect, is just as much a bore as the gloomy pessimist, with his own list of troubles, personal and official, who remarkably achieves the ability of looking just how he feels. Or as one doctor remarked to me some time ago, when I was in a rather depressed condition: "Well, you're paid to have headaches in your business." He should have added that I wasn't paid to *wear* them!

4. Thou shalt give no special privilege to one whom thou likest that thou wilt not give to all, whether thou likest them or not.

We have a wonderful group of people working in our hospital. Only, frankly, some of them don't seem to fit into my personal scheme of things as well as others do. Fortunately, I have never had time to separate the sheep from the goats in my personal judgment. It's a good job, too, for otherwise I may be making some decisions that are favorable to some, and not to the others. Then, I would have forgotten that those for whom I have no personal affinity are possibly just as necessary to the efficient and kindly operation of my institution, and I would have a group of dissatisfied and disgruntled people on my staff, because I had erred in judgment. So when Mrs. —— who does such a remarkable job on Second Floor asks for a special favor, my first question to myself is: Can I agree to the same kind of thing for Miss ——, who seems to do such a good job in the laboratory, but is a pain in the neck to me? This is very simple, basic judgment, but it is sometimes rather astounding how our personal dislikes or appreciation of people overflow into the area of judgment, and dilute the power of our reasoning process. To have this kind of mental gauge in use is perhaps not a bad idea.

5. Thou must be the last one to lose thy head in any emergency.

Not so long ago we had about 30 inches of snow in about 24 hours. I trudged through the drifting snow to see what was happening at the hospital. Someone in charge had seen the great emergency as an opportunity for the display of quick and careful planning of the personnel resources that were available; in addition, there had gone with that planning the most infectious gaiety and good spirits that stayed with us throughout the emergency. Even a couple of staff doctors, who had holed up with us for the night, had caught the spirit of the place, for they were swapping intern stories with intern duties and having a thoroughly good time. In an emergency, you may not know what immediately should be done to counteract the situation, but your head was made to think with—so do not lose it. It is quite a truism that an administrator who loses his head also loses face.

6. Thou shalt stop, look and listen to suggestions.

It is not surprising that out of the day-to-day challenge or boredom of doing the same tasks in a hospital setting there can often arise a really good idea. This may concern the ease or speed of doing a job. Or it may add to the comfort of employe or patient. It is often observed, too, that some of these goods ideas come into being from an area of frustration, or even belligerent objection. "Why in the name of ——?" may be a query addressed by all types of hospital employes expressing some objection to the particular job upon which they are engaged. As we pass by, and hear such a remark, are we not inclined to think sometimes, in our benign way, that the speaker was evidently tired, or had some trouble at home, or had received a recent "stirring" from the supervisor? Instead of which, perhaps it would have been better to stop just at that moment, transfer our thinking to the particular task, look at it objectively, and then see if we can ourselves produce, or get someone else to do so, a suggestion that might improve the efficiency of the job or at least the serenity of the person doing it. Proof of the law of survival may be indicated in the fact that often these suggestions are made out of exasperation or, at least, not from the highest of motives. But that should not prevent our stopping for a moment, looking into the cause, and listening to suggestions, either from others or from our own fertile imagination. Such actions will at least keep some of the tracks fairly clear in the hospital.

7. Thou wilt show thy wisdom by acting as a mental waste basket, if necessary.

This possibly may be in contradiction to Number 6, but on the other hand should rather be considered as giving balance to the two. The waste basket in most administrators' offices gets fairly full at the end of the day: full of unnecessary, duplicated or extraneous material. It also, I hope, holds some "completed" business. Or using another simile, the garbage can is used for scraps which are no longer of use to the household.

We should therefore learn that we become the recipient of the waste or useless material that accumulates in the minds of associates. They want to "throw it off" and we become the recipient. We are going to have a great deal of mental indigestion, with possible physical reactions, if we try to absorb *all* that is thrown at us. It is a wise administrator who can discern between a legitimate suggestion, even if it is surrounded by heat, and someone just emptying out the garbage. I remember a particular stormy interview when a young administrator tried to deal step by step with all the material that an associate was heaping upon him. Finally, having absorbed most of it, this same administrator nearly passed out when he was assured: "Now I feel better I've told you all that, and I don't expect you to do anything about it; I just wanted to feel better!"

8. Thou shalt "Let George do it" for thus only may he show that he can.

One of the evidences of skilled leadership is the ability to trust people to do a new job. That this means taking a chance, and sometimes even a risk, is not gainsaid. Yet the principle remains as one of the best means of providing for and proving the development of personality of the individual. This does not detract from the fact that it is good to be able to do it yourself better than anyone else can or to have the trusted few who can be depended upon to accomplish all manner of ingenious ways of overcoming a difficulty or performing an involved task.

Sooner or later, however, your bones will begin to creak, and your "trusties" will get older, and pass from the scene of things. Then, someone else is going to be responsible, and if he has not had a chance of proving that he can do it, you will not know about it and, possibly worse, if you ask him out of your desperation, he does not know himself if he can do it and we have produced an insecure employe. This gives me a chance to pay a tribute to certain physicians, especially the sur-

gical group on our staff. The patience and understanding with which they train *and trust* the new student nurse who arrives in surgery bi-monthly is an excellent example. They trust her immediately to have comprehended many of the implications of being a scrub nurse; the student's personality takes on a new trend of assurance. Very quickly she is really assisting the surgeon, and all this happens without any regrettable effect upon the patient.

It is, of course, recognized that this approach needs careful balancing, but its principle should be observed in every department. Some wise dietitian did this, and took a chance on the vegetable woman one day when the pastry cook was taken suddenly ill. We discovered a very much better pastry expert — one of the "natural ones"—and when the old one was unable to return, we had profited from the exchange. That this is just another way of stating a basic principle of personnel administration is obvious. But a general rule of this kind can only be worked out in particular instances—so, "Let George do it."

9. When thou makest a decision, seest thou to it that it is based on investigated facts and accumulated evidence.

This is the rule of diagnosis that your physicians observe. The business manager or controller, in his assessment of the financial standing of the institution, does not consider only the operating fund bank account. In all areas of personnel administration, there are facts and figures that can be quietly ascertained, that should be the basis of adjudication of complaint or suggestion. A case of emergency being the only exception, it will always add to the wisdom of any decision if the approach is made with actual facts as stepping stones across the torrent of conflicting human emotions. Then again, the facts may reveal nothing, and we then look for the evidence of personality differences, which have been discovered to produce most astonishing situations.

As a family man, I confess to some of the strongest of differences among my family, which occasionally have left the atmosphere sultry and blue. If this happens between persons with similar genes and chromosomes, and the same environment, then once in a while we may expect the same in the hospital family, where no such similarity exists. On the other hand, when friction develops in engineering, regrinding or retooling may be the better solution than even more liberal application of lubricating material. Administration should therefore be able to discover whether the knock occurs through plain lack of the milk of human kindness, or frankly whether a retooling or redesign would not be in order. Mental calipers are, therefore, an important tool in the kit of the personnel engineer.

10. Thou shalt acknowledge that time is the most expensive item in thy budget.

This commandment is not intended as a plea for time studies, either by experts or self-instituted. Their value is obvious, and should constantly be in the mind of the personnel administrator.

We cannot always value a job in dollars and cents, but in parceling out the work, and especially in the institution of new procedures, we should at least give ourselves an estimate of what it is going to cost—and if the end result is worth it. And if it is not, and we still want the job done, then we can at least agree that we are affording a little luxury, which in these lush days, may be forgivable.

Time, of course, can be wasted like any other commodity. There are some

(*Continued on Page 62*)

A new kind of administrative assistant:

The Administrator-in-Charge

CHARLES G. MARION

Acting Executive Director, Jewish Hospital of Brooklyn, N.Y.

SOME years ago, an analysis of the executive department of the Jewish Hospital of Brooklyn indicated that much time and effort was being spent on the many small details that plague every hospital administrator and interrupt any sort of routine he may have established for the conduct of his daily schedule. This analysis pointed to the expensive time that was spent by top level hospital personnel in handling problems and details that could easily be handled by others. Another point brought to light was the tremendous amount of traffic that finds its way in and out of the offices of the administrator and his staff. Last but not least, the analysis showed that investigative work was performed by top level personnel, which in itself proved to be time consuming.

As a result of the analysis, two administrative assistants were engaged to cover the position of "administrator-in-charge." An office was provided close to the main lobby, the admitting office and the cashier's office. At first, only visitors who had special problems were referred to the administrator-in-charge. Some of the questions they asked are given here to indicate the responsibilities which the administrator-in-charge assumed.

1. "I know it's not visiting hours, but I'm from out of town. May I see patient Jones now?"

2. "The patient in the next bed to my father is very sick and keeps my father from resting. Is it possible to effect a transfer to another room?"

3. "Could you explain the hospital's charges?"

4. "I'm a salesman from the XYZ Company. Could I arrange to have my products exhibited to your staff?"

5. "I am an undertaker engaged by the family of the late Mr. Doe. The resident will not release the body for reasons which he will not divulge to me. Could you help me satisfy my obligation to the family?"

These are but a few of the questions that were sidetracked from the executive office. One can see that the solutions to these few examples require only time spent on the telephone and perhaps visiting the particular area in question. Originally the office of the administrator-in-charge was open from 9 to 5 daily but in a short time the hours were extended to 8 a.m. to midnight. The nursing supervisor on duty from midnight to 8 a.m. remained in charge during those hours.

As time went on, the responsibilities of the administrator-in-charge were expanded. As he became more familiar with hospital procedures and policies, he was instructed to attempt to settle differences between department heads and to refer to the executive office only

(*Continued on Page 62*)

things that are a *must* when it comes to correctness. On the other hand, it would seem essential that we assess the value of absolute correctness against the cost of achieving it. We all realize that the greater percentage of our costs goes to salaries, and therefore the saving of time is most important. Of all departments in the hospital, we have learned that nursing time, especially that of professional nurses, must be the most carefully conserved, not because of budgetary limitations but rather because of personnel shortages. But how about other departments in the hospital, not forgetting our own little domain? If information and statistics are being accumulated, which are not going to be used, then we are wasting a precious commodity. Or, if the results or benefits gained by a study of such statistics do not exceed the cost of gathering them, we are wasting our resources. No doubt many hospitals have instituted new procedures and methods of recording, which give all the information we need plus some time-saving short cuts. But there may be still some tag ends of old methods that are yet being used, and if so, power is being wasted. The old adage about putting a lock on the stable door has definite merit, but so often the locks we install cost far more in time than the old nag that ekes out its existence in the stable. My accountant friends may have a basis for dispute with this suggestion, but it is possible that excellent accounting practice may not always show the best administrative use of time—and there are possibly other areas where time has apparently little value.

Here endeth the Ten Commandments. The very preparing of them has at least given some point to the problems of this administrator. And points can be marks on a compass to guide, as well as needles to give a shot in the arm. May these be both!

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those problems that he could not solve, or those that required top level decision.

With experience came confidence. The executive personnel began to assign projects to the administrative assistants (we now have four), to be conducted in hours when they were not assigned as administrator-in-charge, or so-called "desk duty." These projects involved the investigation of a particular area of the hospital or a phase of hospital operation, or a combination of both. In effect the administrative assistants were doing the "leg work" for the administrator or his assistants. This, of course, provided time for executive personnel to look into many more areas than had heretofore been possible. Furthermore, it placed the responsibility for making decisions upon the executive personnel. It was found that problems were solved more quickly and efficiently and more of the hospital came under the direct surveillance of the executive office.

At the present time, the responsibilities of the administrator-in-charge encompass the following areas:

1. Information service.
2. Messenger and mail service.
3. Emergency room.
4. Security and protection.
5. Telephone service.
6. Admitting.
7. Schedules of (a) commercial exhibitors and (b) auditorium, classroom and conference room functions.
8. Reports to the executive office on (a) emergency admissions and (b) long-stay cases.
9. Emergency house staff coverage.
10. Evening rounds of the hospital, apart from those made by the nursing supervisor.
11. Processing and assisting in obtaining autopsy consents. (This has helped to increase our percentage to 42.8 in the year 1952; 45.1 January to June 1953.)

Insofar as personnel is concerned, the original requirements for the position were minimal. Likely looking candidates who seemed to possess a flair for administration were given an opportunity, regardless of whether the applicants had a hospital background. We have found that we have unconsciously established an excellent training ground for individuals aspiring to careers in hospital administration. In due time these people find opportunities that bring them into contact with every area of the hospital, which is in itself a liberal education in the practical aspects of hospital administration.

Realizing the potential of our administrative assistants, we have established a formal program of orientation. A new man spends a few days in each department and division before he is assigned to "desk duty." This orientation period usually consumes from six to eight weeks, depending upon the individual's background. During that time, and for perhaps a month or more, no projects are assigned. From time to time, approximately every three to four weeks, a formal discussion is prepared and conducted by a member of the executive department or other top-level department heads. These discussions may cover such topics as hospital organization, medico-legal aspects of medical record keeping, principles and practices of hospital accounting, purchasing, and so on.

Other round table discussions are scheduled for general and specific problems of the hospital as they affect the administration. Administrative assistants are encouraged to attend conventions, institutes and seminars conducted by national and local hospital organizations.

This program was established approximately three years ago and to date one administrative assistant has advanced to a position as assistant director of a large hospital now under construction and a second has been promoted to assistant director in our own institution.

We have found that graduates of a formal course in hospital administration, who have served an administrative residency, are most suitable for this position. It affords an opportunity for the individual quickly to put his learning to use in a large hospital situation and, of course, it greatly lessens the training period on the part of the institution.

Because the universities offering the formal education in hospital administration accept students usually on a full-time day basis, it is no doubt difficult for many individuals possessing administrative talent to take advantage of this training. We have found that the position of administrator-in-charge requires an individual with a mature mind. In most instances such people have certain obligations and responsibilities which make it impossible to make a financial sacrifice that extends over a period of approximately two years. Our program opens the door to personnel seeking training in hospital administration without severe financial sacrifice. It is agreed that this entire philosophy may be a step backward, but the advantages to both hospital and individual, in my humble opinion, far outweigh contrary arguments.

Photographs taken at South Shore Hospital, Chicago, by Publix Pictorial Service, Inc.

Mrs. Jacobi, blood bank supervisor, typing and checking the Rh factor of a donor's blood.

How to Install a Blood Bank

DONYA JACOBI
Blood Bank Supervisor
South Shore Hospital, Chicago

LIKE any new venture in life, starting a blood bank from scratch seems a complex task full of obstacles and insurmountable difficulties. But if one actually stops only toying with the idea and decides definitely that it is an essential service of every small hospital doing surgery and obstetrical work, that having blood available immediately reduces mortality, and that the doctors feel at ease knowing that any grave hemorrhage or accident can be treated without any loss of precious time, then the task is not nearly as difficult as it first seemed to be.

There are three important ingredients that help: some organizational talent, a lot of common sense, and experience in this fairly new field. These ingredients well mixed and integrated should produce satisfactory results.

Blood banks have operated in the United States since 1937. The first one was established in that year in Chicago in Cook County Hospital by Dr. B. Fantus.* Since that time many a blood bank has been operated in hospitals of different sizes with various improvements, but on basically the same principles, to have blood available for any given case that needs it immediately. Consequently, the amount of blood used in hospitals has multiplied a hundred-fold since that time. There were 1500 blood banks operating in the United States in 1952. Many physicians are anxious to have this number raised still further and to have blood banks installed in smaller hospitals, too.

Fifteen years ago when I worked as a medical technologist in the laboratory of a good sized hospital, whenever a serious accident occurred or a patient was bleeding profusely, I was called to the laboratory at any hour of the night. We had to make numerous calls to friends and relatives of the patient, rouse them out of their sleep, and explain what had happened. And in the laboratory a search started for the type of blood the patient needed. Sometimes in the rarer groups of blood the search went on for quite some time. More friends had to be called, much valuable time was wasted in typing prospective donors; cross-matching them and doing a Kahn test took more time. At best it took hours before the patient could have much needed transfusions.

How simple in comparison is the procedure today. We keep all types and all Rh bloods available in the bank and the patient can have blood in a matter of minutes. For grave emergencies we have one or more units of O Rh negative blood available that can be given to any type or any Rh patient, if necessary without cross-matching. After the first unit is started, some time is gained in which the exact type and the Rh of the patient can be established and more transfusions of his own type of blood can be prepared in case of need.

Apparently one of the commonest reasons so many smaller hospitals hesi-

*Fantus B., Cook County's Blood Bank, Mod. Hosp. **50**:57 (January) 1938.

tate to open a blood bank seems to be the lack of suitable space. At least I found this to be true in many cases. Of course, it is wonderful to have a suite of large rooms, but actually a bank can function quite efficiently in a small space if it is well planned and properly laid out. For instance, I opened one bank in a former waiting room, another one in a patients' ward. They both worked out well and have since been enlarged considerably. All that is required is a good sized, pleasant, light and airy room. It should have at least one unobstructed window that can be easily opened to admit fresh air. The blood bank should be centrally located so that quick deliveries of blood can be made to all parts of the hospital. It should also be close to the general laboratory. It must have cold and hot running water, telephone service and heavy duty electric outlets. There should be a waiting room for donors near by supplied with comfortable chairs and reading material.

EQUIPMENT FOR OFFICE

From the main collecting room an office can be partitioned off in which the donor's history is taken and, if necessary, a physical examination can be made. This office should contain a desk, filing cabinets, a typewriter and miscellaneous office furniture. The room for blood collecting should contain at least one cot or examining table where the donor can rest comfortably. Every cot should be provided with a small pillow and a wooden arm board covered with a clean towel. The most practical examining tables are covered with washable plastic material. It is preferable to have two such cots or examining tables. They can be arranged side by side with a passage left in betweeen where a small table can be placed for utensils necessary for collecting.

The size of this room and the number of cots or examining tables depend, of course, largely on the number of donors to be handled simultaneously. It is much more practical to start with two tables. We started in the South Shore Hospital, Chicago, with one and after four weeks added another. With proper arrangements two donors can be bled at the same time by one person in charge. Good illumination is essential. A screen is desirable for use at times when one donor might become ill while another is giving blood.

On the donor table, which should be situated between the two bleeding cots, should stand one or two blood pressure machines, depending on how many donors are to be bled at the same time (the aneroid type is very satisfactory since the cuff can be used as a tourniquet); a stethoscope; jars with sterile gauze, sponges and cotton; a bottle of 3 per cent tincture of iodine, 75 per cent alcohol, or any other satisfactory antiseptic solution for cleansing the donor's arm; a number of sterile 2 cc. syringes; a number of sterile 27 gauge needles 1 inch or ½ inch long; a bottle of novocaine, 1 per cent (optional); bandages; a bottle of aromatic spirits of ammonia, and an oral thermometer.

The all-important piece of equipment, of course, is a refrigerator. It is the item *sine qua non*. It should be a sensitive, electric model with thermostatically regulated temperature, preferably a vertical one, with revolving shelves. It should have a recording thermometer and be equipped with a temperature alarm. The alarm should ring at the engineer's office whenever the temperature deviates too much from the one set on the thermostat. A good refrigerator is the most essential part of equipment of a blood bank. It is also the most expensive item, but it quickly pays for itself if it performs well and needs little maintenance.

When blood is collected by gravity it is quite necessary to shake the bottle in order to mix the preservative and anticoagulant solution with the blood. A small floor model agitator is extremely useful. It is turned on very low speed and placed between the two collecting cots. Two bottles can be placed on it if collecting from two donors is done simultaneously.

The pathologist or physician in charge usually decides what type of equipment is to be used in the bank. It is largely a matter of preference what type one wants to use. We prefer drawing by gravity, probably because we have become accustomed to it and have had excellent results with it for the past six years. The commercially prepared bottles of 500 cc. capacity containing 125 cc. of ACD solution meet with the standards of the N.I.H. They are sterile pyrogen free, equipped with labels and ready to use, and are sold as vacuum or gravity containers. The home-made equipment is obsolete, dangerous and, also, in the long run, more expensive.

Disposable donor sets may also be purchased through various supply houses. Some donor sets are provided with a sterile needle at each end of the tubing, and in the case of drawing by gravity a sterile air vent needle is also supplied. They are packaged sterile and ready for use. These donor sets are somewhat more expensive since they are used only once, but considering the time involved in cleaning, sharpening and sterilizing needles (and they must be sharp, very clean and, of course, sterile) one wonders if there is much saving in providing one's own needles. If time is no factor, and if there is ample trained personnel to take adequate care of the needles, it might be wise to economize. Otherwise, it is far better and safer to purchase disposable donor sets with needles. A small institution has hardly enough personnel for taking care of needles.

Sterile pilot tubes should be attached to the collecting bottles bearing the same serial number as the bottle and the donor card. They should be filled directly from the donor set while the needle is still in the donor's veins. Labels can be ordered to comply with the requirements of the N.I.H. in different colors for the different types of blood for quick and easy identification.

NEED LARGE WORKTABLE.

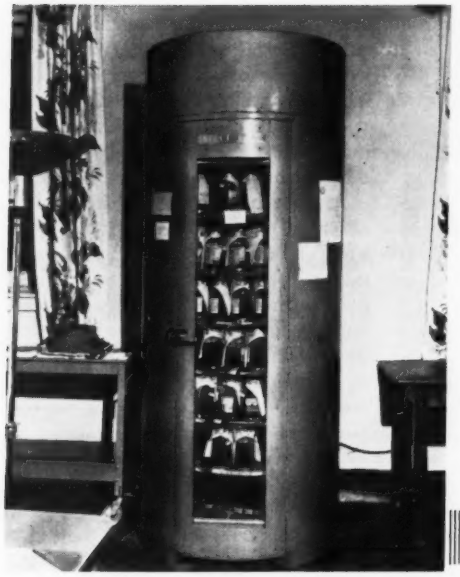
A spacious working table that can be arranged along the longest wall of the office space should also be provided. Copper sulfate bottles, specific gravity 1053, can be kept there for determining the donor's hemoglobin. There, also, may be kept clean sterile lancets or disposable hemolets. On the same table should be an Rh viewing box with adjustable heat and light source and provided with a thermometer as manufactured by the Michael Reese Foundation in Chicago; finally, there should be slides, test tubes, applicators and various small items necessary for performing, typing and Rh testing.

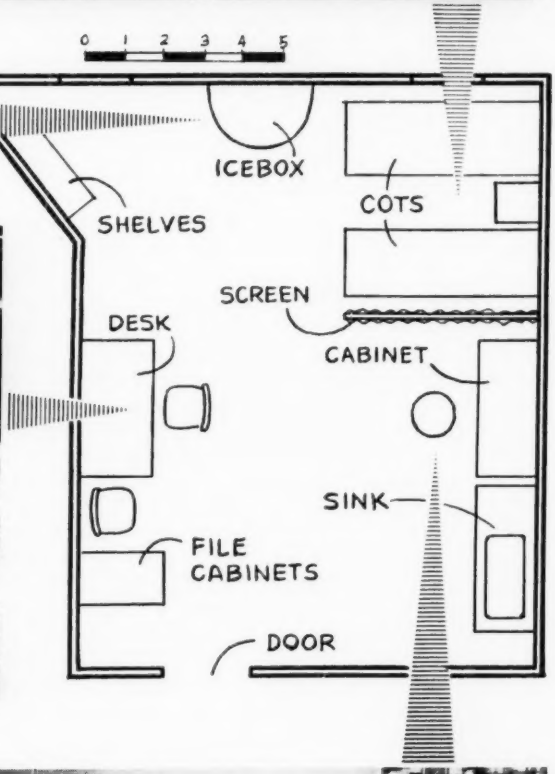
Typing and Rh serums should be purchased from a commercial company approved by the N.I.H.

Storage space for bottles, supplies and linens can be arranged in suitable cabinets either under the bleeding cots or under the main working table.

Before blood is collected from any donor after he has passed the health requirements, he must sign a release. This is a printed form on the reverse side of the donor card, and states that the donor presented himself voluntar-

(*Continued on Page* 66)





Top, left: The refrigerator is the central piece of equipment. It should be a sensitive, electric model with thermostatically regulated temperature, with revolving shelves. Top, right: Two cots can be set up side by side with the donor's table between. Center, left: Donor's history is taken in the office. Center, right: Suggested plan for a blood bank. Bottom, right: An Rh viewing box is an essential tool.

ily for the withdrawal of 500 cc. of blood and that he assumes responsibility for any untoward reactions incurred during or after the donation. His signature is witnessed by the person taking his medical history. It should, of course, be properly dated. This release should be kept on file after the disposition of the blood for a considerable length of time depending upon the statute of limitations in the particular state.

A number of various forms and records is connected with conducting a blood bank. The book work, *i.e.* filling in forms, keeping different files for patients and donors and the careful accounting of patients' debits and credits of blood, is quite formidable. In a large institution it is usually done by a secretary or some other clerical assistant. In a small hospital it may be handled by the technician.

KEEP DAYBOOK OF DONORS

A daybook should be kept with complete entries of all donors from whom blood was taken on a particular day, with information as to whom credit should be given for the blood, the donor's serial number, name, address, telephone number, date of donation, type and Rh factor.

A file of donors should be kept with information supplying the same data. All Rh negative donors should be taken out of this file and kept separately for building up an Rh negative file. Every donor should receive a card bearing his name, Rh factor, and date of donation.

Also to be kept is a book with patient's name and serial numbers of blood received by him. On the opposite page of this book all donors who gave blood for this particular patient are to be entered by serial number of their blood. In this manner one glance can reveal the patient credit or debit to the bank.

Suitable labels should be provided for the blood collecting bottles with enough room for the donor's name, blood, serial number, date of collection, date of expiration, type of blood and Rh factor, and serological result of an acceptable test.

Although every blood bank is under the direct supervision of a pathologist or other qualified member of the medical profession, the routine operation of the bank is, of course, entrusted to an experienced medical technologist who is intelligent enough to know when to consult her superior.

It is quite difficult to select a person who is efficient and qualified to run a blood bank. She must be very well trained, familiar with bacteriology, serology and hematology; she must be progressive, willing to keep on learning and reading current literature pertaining to this field. She should have considerable previous experience in laboratory technic. She must be completely reliable, honest and conscientious, have a pleasant disposition and should be interested in people, or at least give the impression that she is. Putting a donor at ease previous to donation and during bleeding is of great help and lessens unfavorable reactions considerably. Diverting the donor's attention from the act of giving blood by light conversation about the donor's occupation or any other noncontroversial subject is helpful. The donor must be made to feel that he is doing a good deed or is performing an important function.

The staff members of the hospital should have complete confidence in the competence of the technologist. They will then not hesitate to order any transfusion for a patient, no matter how complex that particular patient's problem may be, if they feel the technologist in charge is familiar with the more difficult phases of transfusions and possible reactions.

There will be times when even the best functioning bank will have to get outside help. One Rh negative patient in serious condition requiring many transfusions can deplete a bank in short order. There are many ways to remedy such a situation. If it happens at night it is best to buy blood from an established commercial bank. One can also call up previous donors whose type and Rh factor are in the donor file. Usually they are quite willing to help out in an emergency, especially if compensated. Another possibility is to set up an exchange service with another hospital bank, one preferably not too far removed. It is desirable to know the person in charge of such a bank and be somewhat familiar with her technic. It works out very nicely most of the time. In this manner it is possible to dispose of rarer types of blood that were not used before they expire, and it helps both banks to be able to call each other in time of need. Usually a cab is called and the blood is given to the driver to deliver. This we have found to be the quickest and most satisfactory way of exchange.

A well run blood bank in a small or medium sized hospital need not have daily hours for drawing. It is quite sufficient to have three days each week for donors. The hours should be staggered to allow donors to give blood after their regular working hours. Evening hours, at least once a week till 8 or 9 p.m., have proved very helpful.

A blood bank in a small hospital is never a financial burden. If economically and efficiently run it accumulates money for expansion. It is of great help when the opening of a new blood bank is contemplated to visit hospital blood banks of various sizes, to talk to persons in charge and observe their methods. Many an idea can be obtained in this way, and acquainting oneself with the actual operation is stimulating to one's own trend of thought.

An important factor for the existence of many small and medium sized hospital blood banks is the fact that, in any national disaster, dispersed small banks are of much more value than, say, one or two large banks that might conceivably be put out of operation for any length of time. Once the fundamentals are there, a small bank can be enlarged easily in a national emergency.

WHERE TO GET BLOOD

The question of how a new bank gets capital or blood can be answered simply. All hospitals have used blood previous to having established their own banks. If the blood was purchased from a commercial bank, the donors are told to replace at the new bank in a ratio of two to one. If a newly admitted patient is going to surgery or will need transfusions for any other reason, the physician in charge of the patient can usually arrange to have the family deposit blood at the bank prior to the patient's need. In this manner a small starting stock is built up and it grows amazingly fast.

In conclusion, I would like to say that running a blood bank is one of the most satisfying and gratifying occupations in the medical field I know of. It is good to have the feeling that one has done something very useful and has helped in a grave emergency to save a life. A donor once asked me: "Is that all you do all day? Take blood from people? It must be a gruesome job." When I asked him: "What do you do?" he answered, "Oh, I am a grave-digger." So it is apparently all a matter of preference and interpretation.

THE MODERN HOSPITAL OF THE MONTH

Architect's drawing of the projected 500 bed, 10 story Long Island Jewish Hospital at Glen Oaks, which will be constructed in three stages.

LONG ISLAND JEWISH HOSPITAL

Time and Distance Determined the Plan

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Consultant and Executive Director
Long Island Jewish Hospital, Glen Oaks, Long Island, N. Y.

LOUIS ALLEN ABRAMSON
Architect, New York City

WHEN the planning began for the new Long Island Jewish Hospital it was agreed that the controlling criteria for the basic unit floor plan would be the time and distance involved in rendering essential services to and from the patient's bedside. Furthermore, in order to achieve a plan that would best meet these criteria, as well as achieve integration, comfort and safety, it was decided to make comparative studies of the following elements in alternative floor plans: total perimeter per bed per floor, area per bed, beds per nursing unit, distance from nurses' station to distant bed, distance from utility room to distant bed, distance from pantry to distant bed, and ratio of patient room area to total area. Finally, it was decided to fix the single nursing unit at a 40 bed maximum and a 30 bed minimum with no more than four beds per ward room, and with all semiprivate and private patient rooms of two and one bed capacity. These studies were to be made, initially, without consideration of costs or esthetics.

The first plan to be explored was circular in form (Fig. 1) with all ancillary facilities within the hub, the latter bisected by service corridors. After a number of studies of circular forms this scheme was abandoned as was the square form (Fig. 2) when it became apparent that the periphery which was automatically determined by the space requirements of the nursing rooms and the hub exceeded that in any other plan when the predetermined maximum bed capacity for a single nursing unit was held at 40 beds, and the periphery for multiple nursing units was excessive.

Next to be studied were rectangular forms of various sizes enclosing both single and multiple nursing units (Figs. 3 and 4). These were found to possess advantages over the circular and square forms. However, it was apparent that excessively long principal and secondary corridors would be required if we adhered to the bed limits and thus these forms, too, were rejected, at least temporarily.

A modified dumbbell form (Fig. 5) was then studied. It involved a nursing unit at each extreme and the elevators, pantries, public toilets and other services common to both units placed in the connecting wing. The devel-

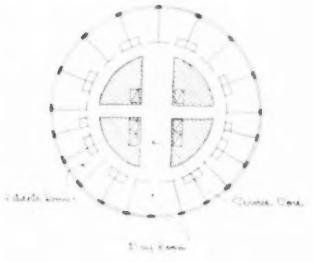


Fig. 1: Circular plan with all ancillary facilities within the hub.

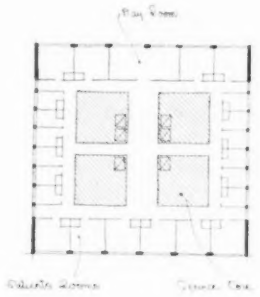


Fig. 2: Square plan. The periphery was excessive.

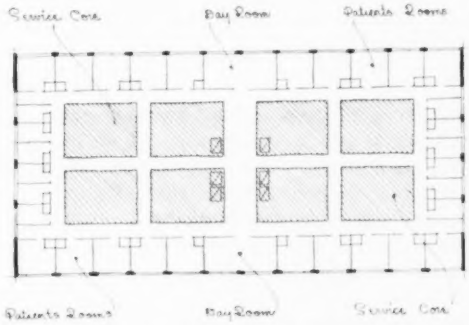


Fig. 3: One of the rectangular forms enclosing both single and multiple nursing units which was studied.

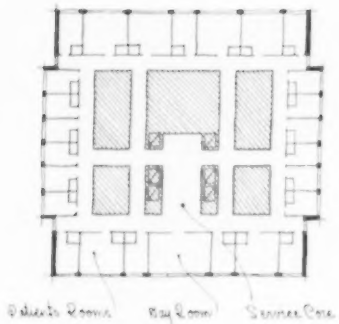


Fig. 4, left: Another of the rectangular forms rejected because principal and secondary corridors would be excessively long.

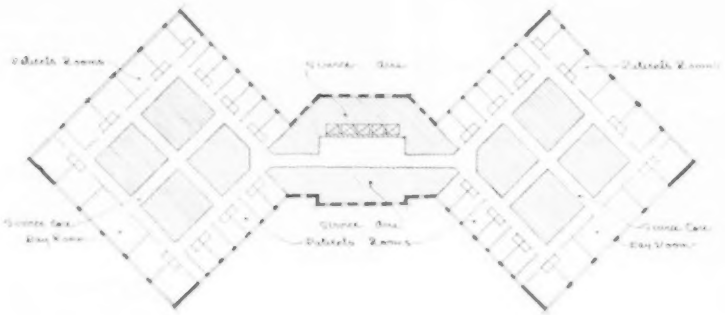


Fig. 5, above: The modified dumbbell form involved a nursing unit at each end, with elevators, pantries and other services in the corridor.

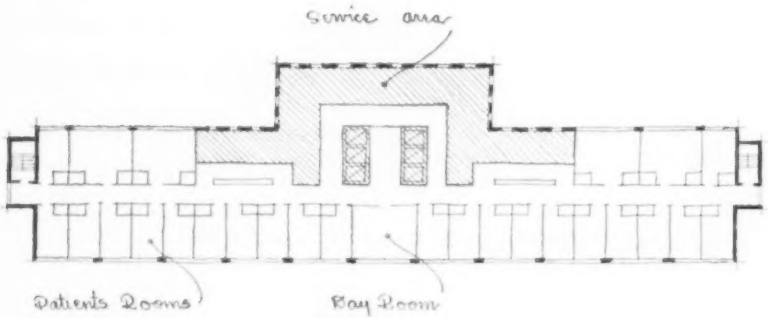


Fig. 6, above: The traditional layouts were also contemplated, like this one in which the service facilities are shown by shaded area.

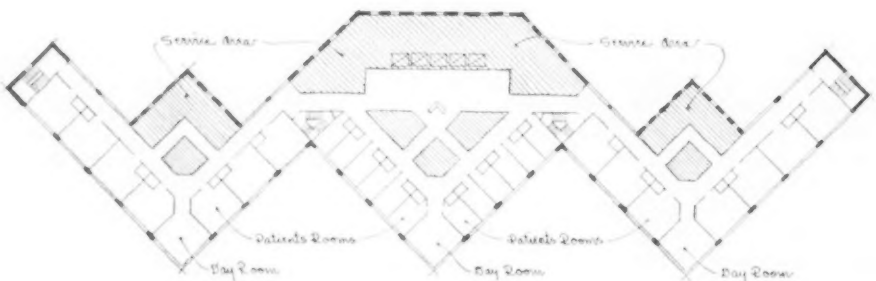


Fig. 7, above: Among the novel designs was this one shaped like a "W."

opment of this form revealed several disadvantages, principally, however, the requirement of an excessive area in the connecting element. Exploratory studies were also made of various traditional forms (Fig. 6) as well as of some which might be termed novel (Fig. 7).

Finally, studies were prepared of double nursing units employing parallel corridors, each unit being complete with all required ancillary services placed between the parallel corridors. One such form (Fig. 8) provided for the ancillary and service rooms to open off both parallel corridors—a type of double corridor plan which may be considered the prototype of all such plans. In the plan finally adopted (Fig. 10), the service rooms were designed wherever practicable so that their doors opened on cross-corridors rather than on the main lateral parallel corridors. (See article starting on Page 70.)

The advantages of the plan finally adopted emerged clearly after a careful comparison was made with two of the other plans selected as the best among those studied and after all three were compared with the standard single corridor rectangular plan recommended by the United States Public Health Service (Fig. 9). The elements se-

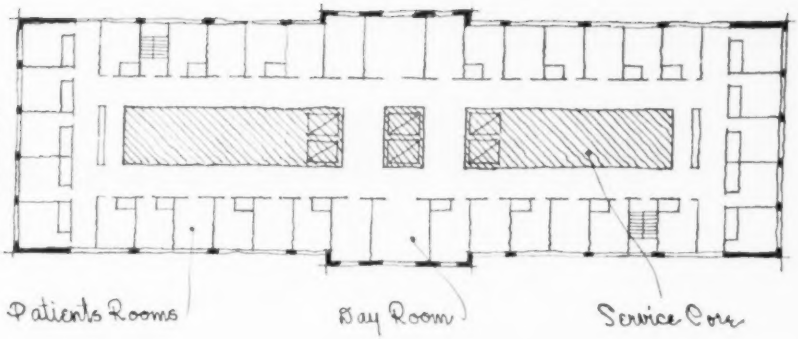
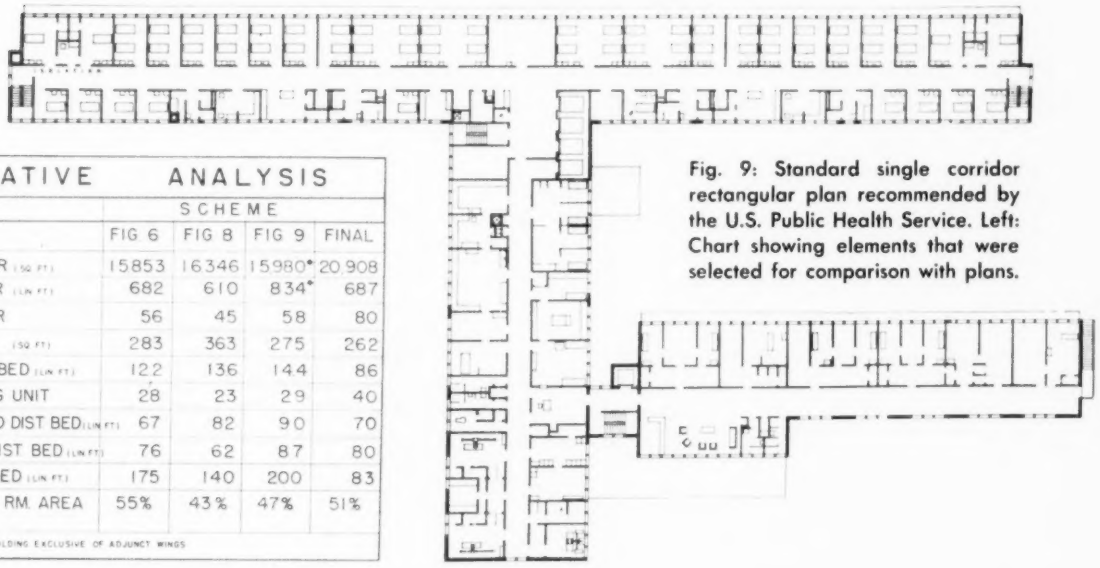


Fig. 8: Double nursing unit employing parallel corridors. This plan provides for ancillary and service rooms to open off both corridors.



COMPARATIVE ANALYSIS	SCHEME			
	FIG 6	FIG 8	FIG 9	FINAL
AREA PER FLOOR (SQ FT)	15853	16346	15980*	20908
TOTAL PERIMETER (LIN FT)	682	610	834*	687
BEDS PER FLOOR	56	45	58	80
AREA PER BED (SQ FT)	283	363	275	262
PERIMETER PER BED (LIN FT)	122	136	144	86
BEDS PER NURSING UNIT	28	23	29	40
NURSES STATION TO DIST BED (LIN FT)	67	82	90	70
UTILITY ROOM TO DIST BED (LIN FT)	76	62	87	80
PANTRY TO DIST BED (LIN FT)	175	140	200	83
RATIO OF PATIENT RM AREA TO TOTAL AREA	55%	43%	47%	51%

* ONLY MAIN MASS OF BUILDING EXCLUSIVE OF ADJUNCT WINGS

Fig. 9: Standard single corridor rectangular plan recommended by the U.S. Public Health Service. Left: Chart showing elements that were selected for comparison with plans.

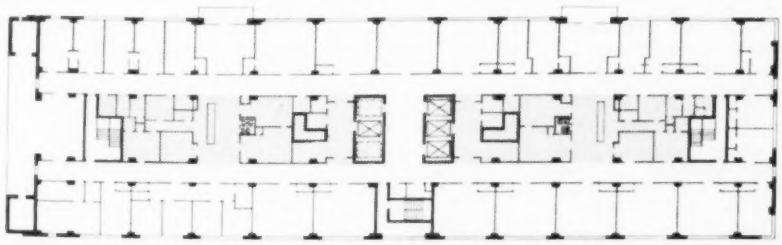


Fig. 10: In this plan, which is the one finally adopted, service rooms were designed wherever practicable so that their doors opened on cross corridors.

lected as the bases for comparison are shown in the accompanying chart.

It should be noticed that with two nursing units for a maximum total of 80 beds the entire perimeter is much less than in the single corridor plan and that the increase in floor area is roughly proportional to the greater number of beds. The area per bed, however, despite the greater number of beds, is considerably less than that in any of the other plans. This is also true of the perimeter per bed and of the pantry to distal bed distance. The distance of nursing station to distal bed falls within the median range of the other plans, but the cross corridors in the adopted plan provide considerably more flexibility. Finally, despite the greater number of beds per nursing unit the ratio of patient room area to total area compares favorably with the other plans.

The simplicity of form in the plan finally adopted also pointed to certain construction economies. It is interesting to note that the savings effected by the simpler form, employing as it does a uniform module, actually resulted in sufficient savings to permit inclusion of a system of air conditioning throughout the hospital.

LONG ISLAND JEWISH HOSPITAL

The Tenth Plan Passed All Tests

Designed to function efficiently as it grows, the hospital will open with 214 beds and progress through three phases to its ultimate capacity of 500

EUGENE D. ROSENFELD, M.D. and LOUIS ALLEN ABRAMSON

IT IS rare in the history of hospital construction that the architect and the hospital consultant are given free rein to plan the hospital of their dreams. It is even more unusual for circumstances to exist that permit the architect and hospital consultant even to approximate their dreams in actual construction. The Long Island Jewish Hospital in Glen Oaks, Long Island, N.Y., now 90 per cent complete and scheduled to accept its first patient this year, is a product of such circumstances.

From its inception, the hospital has had the kind of support that fosters an atmosphere in which imaginative planning and bold departures receive ready consideration if not enthusiastic backing. In part, it stemmed from the fact that the unprecedented growth of Long Island's population in the last decade had not been accompanied by any commensurate development of health and medical facilities. Existing hospitals were seriously overcrowded and in a great number of cases hospital treatment had to be sought a considerable distance from the local community—in the Bronx, Brooklyn or Manhattan. Thus there was a keenly felt public need for new hospitals, a need that had been dramatically demonstrated in reports issued by the Hospital Council of Greater New York. And, happily, ready to do something about this situation was the federal government with a promise of $1,530,000 in Hill-Burton funds and the Federation of Jewish Philanthropies of New York with a grant of $500,000 and aid in raising additional funds from the community which has, to date, contributed $4,250,000.

The Long Island Jewish Hospital is set in a beautifully wooded and landscaped 8½ acre plot within a stone's throw of the boundary between Nassau and Queens counties. It is located at the heart of the island's main highways and transport arteries and it is swiftly accessible from any point in both counties. The entire site was made available by the Hillside Hospital, a voluntary psychiatric hospital for noncommitted patients, which is also affiliated with the Federation of Jewish Philanthropies. Hillside lies 250 yards to the west and shares the same landscaped area. Altogether there are 52 acres of contiguous land belonging to Hillside and the Long Island Jewish Hospital that will make considerable expansion of both institutions possible in the future.

Since the hospital is located in a semirural area, it has been possible to set the building sufficiently distant from the street to prevent future construction enthusiasts from destroying the beauty of the approaches. The plot plan shows parking facilities on the plot itself and the division of service, ambulance, visitor and doctor traffic. The hospital site is further enhanced by a landscaped and wooded golf course to the north and a wooded plot, owned by Hillside Hospital, to the east. This latter plot, incidentally, is protected from encroachment by commercial or housing construction by a 34 acre farm which also cuts the hospital off from traffic on the adjacent highway. The area to the west contains the buildings of Hillside Hospital and some 34 acres of land. The area to the south, across 76th Avenue, contains new housing developments and new, moderate priced homes and should provide a good source of labor. Finally, it should be pointed out that Hillside Hospital, a 197 bed institution, and the Long Island Jewish Hospital will together have the opportunity of developing coordinated programs for the care of the mentally ill and the physically ill. Such an opportunity has been quite rare in the history of program development in voluntary hospitals.

The Long Island Jewish Hospital is a voluntary, nonprofit institution and it will make its facilities available to all in Queens and Nassau on a completely nonsectarian basis.

Our ultimate goal is a full 500 bed institution. Because sufficient funds for a hospital of this size were not initially available it was necessary that the product of the first phase of construction be viable in terms of future expansion—sufficiently viable to permit expansion as funds became available without having to redesign, relocate or reequip the originally existing facilities. When it opens this spring, the Long Island Jewish Hospital will have an initial capacity of 214 beds and 40 bassinets. The structure consists of a subbasement, ground and

five floors. It will be expanded eventually by the addition of four floors and by extension wings on three of its four facings.

All departments of the hospital were either created at the 500 bed level or can be expanded to that level.

We were aware that failure to plan for expansion has often resulted in drastically increased costs and in extremely inefficient plants. To avoid such eventualities the final 500 bed institution was planned first, and then the program was cut to its present stage by reducing initial construction costs and deferring the creation of certain facilities. But all utilities, all risers, air conditioning equipment, the power plant, laundry, kitchen and dining services were created at the 500 bed level from the very beginning. The laboratories on the ground floor and diagnostic services were so designed and placed that by simple horizontal extension they can be expanded for their full operating load. This also holds good for the operating room suite and the eight-bed postoperative nursing (recovery) unit. Both were deliberately located on the first floor to allow for expansion without other units being disrupted and to permit additional ceiling height and space which would not have been available if these units had been planned within the main body of the building. Moreover, the location permits the expeditious handling of emergency and accident cases. Administrative services, storage and shops can also be expanded through horizontal construction. The four floors to be added at a later date have been further anticipated by providing shafts for additional elevators, dumb-waiters and conveyors, and by capping all vertical utilities at the roof line and making them large enough from the beginning for the planned additions.

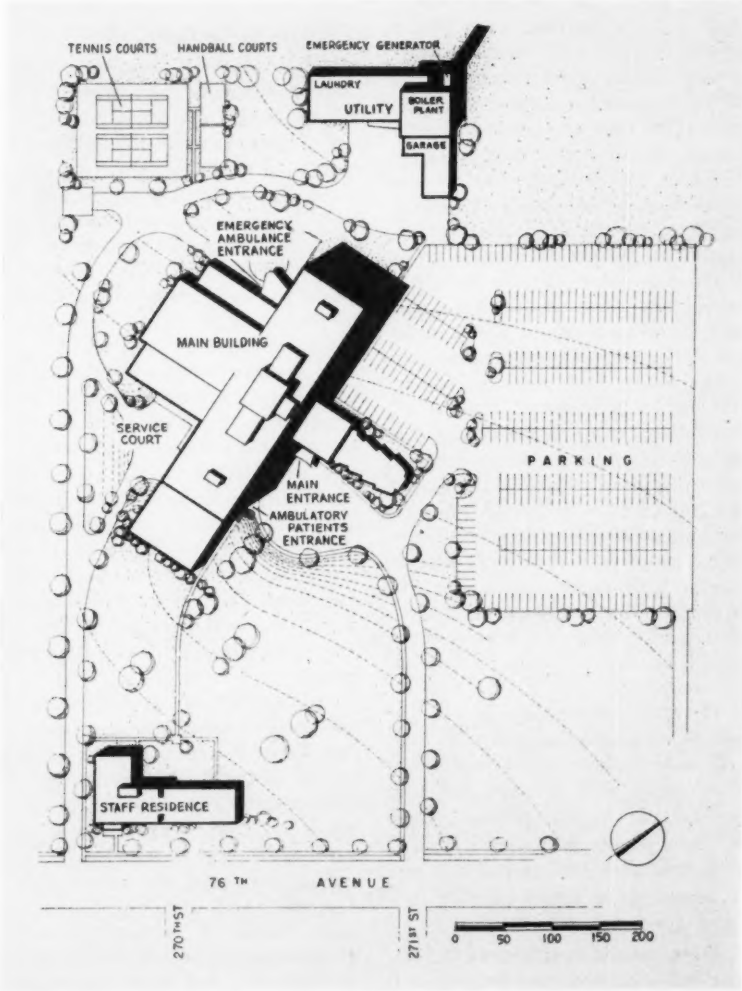
The reinforced concrete columns and slabs were also designed to accept the burden of four more floors. This projected expansion will provide from 280 to 320 beds, depending upon the ratio between ward, semiprivate and private accommodations shown necessary by experience. It is also planned that some of the additional beds will be used for long-term patients.

The hospital design was guided by two fundamentals of service. First, where functional relationships existed between facilities, there should be as close an integration as possible. In order to put this concept into design, the administrative technics and the intradepartmental and interdepartmental operating patterns were worked out in advance of architectural planning. Second, services and functions would be performed mechanically wherever possible. It was understood that only the most advanced or proven mechanical and technological equipment would be introduced and then only if it could clearly achieve economies in personnel and in the expenditure of energy and, at the same time, provide a higher level of patient service.

A number of basic planning and time-distance studies were made of alternative solutions to the problem of traffic flow, communications, expansion possibilities, cubage, area per bed and per service, orientation, and departmental integrations. These studies compared single corridor plans, double corridor plans involving 12 foot to 15 foot interior cores, "T" forms, "L" forms, "H" forms, "X" forms, and also some of the more imaginative layout patterns suggested in recent years. The fundamental nursing unit which finally emerged from these studies, and from which the format of the building followed, involved a double corridor with a 24 foot interior core. All utilities and ancillary services within the core open on cross corridors rather than patient corridors. This design made it possible to reduce the distance from nursing station to farthest patient room to 62 feet.

Adoption of the interior core pattern

Plot plan of the main building showing its relation to the parking facilities, and the division of service, ambulance, doctor and visitor traffic. The site is enhanced by a landscaped and wooded golf course.



required solutions to a number of problems which other plans avoided. It was first necessary to consider whether the four exposures created by placing the patient rooms on the periphery of the nursing units brought any real disadvantages. Since the building is provided with the equivalent of air conditioning, the absence of orientation in all patient rooms to the prevailing breezes was not considered to be of any significance. At some time during the day, in all seasons of the year, every patient room will receive sunlight so that the problem of orientation to sun was also adequately covered. And the orientation of patient rooms to view presented no problem inasmuch as adequate expanses of grass, gardens and stately trees would be seen from all four exposures.

AIR CONDITIONING PROVIDED

The problem of ventilation for the interior core was handled through the provision of forced draft ventilation and air conditioning. Lighting in the interior, unfenestrated core is artificial, but the values gained by providing short distances and a high concentration of utility and ancillary services far outweighed the disadvantage of artificial lighting. Moreover, occupancy of the interior rooms is intermittent and seldom for long periods of time by either patients or personnel.

Modern mechanical equipment will assure ventilation and lighting at all times. Stand-by and emergency generators, accessory ventilators and motors are provided in case of temporary mechanical breakdowns.

The hospital will have a unique, all-year, air conditioning system utilizing radiant energy and subterranean water. During the summer, underground water (natural temperature 50°F.) is circulated through ceiling and wall coils to cool the exterior rooms, while in the winter, the same coils are utilized for the circulation of heated water. An elaborate control system utilizes some 300 thermostats to regulate the panel heating or cooling in each of the hospital's rooms or work areas. The temperature of the air fed into the core and exterior rooms is further controlled by an outdoor sensing element that regulates air temperature and humidity in proportion to weather changes. The water for the radiant panels is pumped from the wells by a modified heat pump arrangement that is expected to reduce fuel bills. The harnessing of radiant energy introduces a new approach to temperature control that will bring about considerable improvement and comfort. Previously comfort was considered an air temperature problem. With the new system comfort can be maintained without regard to air temperature. The system is based on the same principle which makes the thinly clad skier comfortable. Despite the cold air, the sun rays from the snow make the skier feel warm.

The 214 beds of the hospital are distributed as follows: The northeast wing of the second floor has a 40 bed medical nursing unit composed of seven 4 bed rooms, four 2 bed rooms, and four 1 bed rooms. This unit will be operated interchangeably for service and semiprivate patients. Assignment of a patient to a one, two or four bed room will be made on the basis of medical requirements and not financial classification.

The third floor has a 32 bed, 40 bassinet obstetrical nursing unit, three delivery rooms and five labor rooms. There are five nurseries, each with a capacity of eight to 12 bassinets. Each nursery services eight maternity beds and each nursery is isolated from the other. This floor also has one suspect nursery. The isolation nursery is included in the pediatric unit on the fourth floor. In addition, a 24 bassinet premature nursery center is being constructed on the first floor where it can be approached directly from the ambulance entry. This center will serve prematures from all of Long Island and will be run as an independent unit.

The fourth floor pediatric nursing unit has 38 beds and an eight to 12 bed isolation nursery. The nursery will be used for the isolation of newborn infants, as well as those up to eight and 10 months of age. A 40 bed nursing unit on the same floor will house both semiprivate and service adult surgical patients and assignments will be made on the same principle of interchangeability described previously in connection with the nursing unit on the second floor.

The fifth floor contains two 30 bed private nursing units, each with two-bed and one-bed rooms exclusively. These units will be used for both medical and surgical patients. Eight of these private rooms are de luxe, with their own showers, and they can, if necessary, be converted into two-room suites.

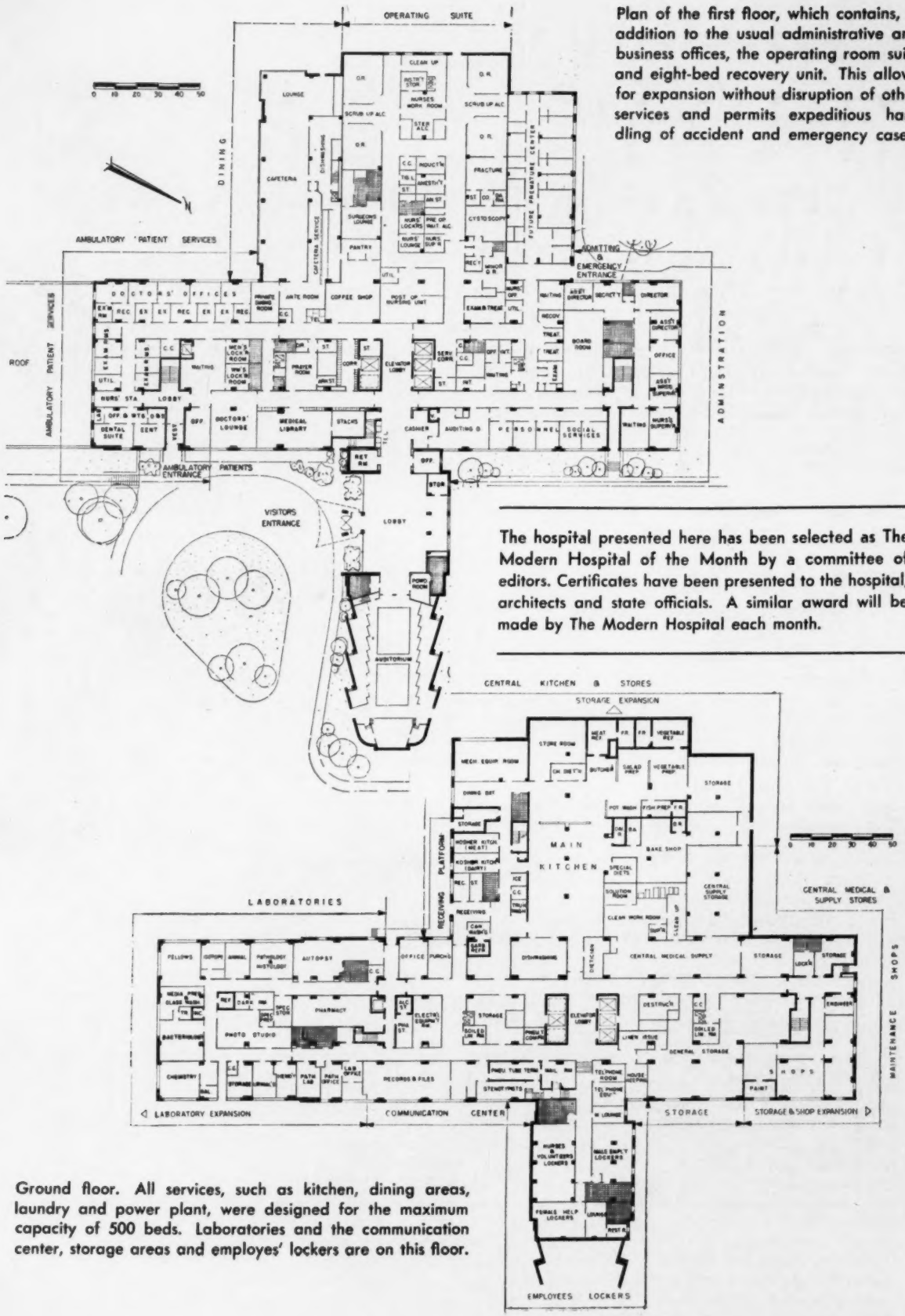
Every patient room throughout the hospital—four-bed, two-bed, or one-bed—is provided with its own water closet equipped with bedpan-flusher, wash basin, and clothes lockers. In addition, every patient is provided with two-way audio-visual communication which enables patient and nurse to speak with each other at all times. Every room has oxygen and suction outlets as well as central television and radio jacks at the head of each bed. Specially designed overbed lighting fixtures provide for general illumination as well as reading and examining lights for all patient units.

In connection with the teaching program, there will be a 350 seat auditorium which extends from the main lobby of the hospital. It will be used not only for student training but will be available to the community for educational purposes. Every nursing unit has a large, light, airy day room with a railed balcony and each floor is provided with a conference room large enough to handle a group of 40 students.

25,000 TO 30,000 CLINIC VISITS

The ambulatory patient services are designed to handle approximately 25,000 to 30,000 outpatient visits per year. The department will utilize the south wing of the first floor and parts of the diagnostic units on the second floor. There is a separate entrance to the ambulatory patient services off the main entrance drive, thus keeping inpatient and outpatient traffic separated but permitting the same diagnostic and therapeutic services for both. A separate hydraulic elevator for the use of outpatients connects the first and second floors. It should be noted that this outpatient service is so designed as to make lateral expansion easy and inexpensive. As part of the diagnostic and outpatient services there are separate lounges, dressing rooms, locker rooms and toilets for ambulatory male and female patients, thus eliminating, in part, the need for separate dressing rooms off all examining and diagnostic rooms.

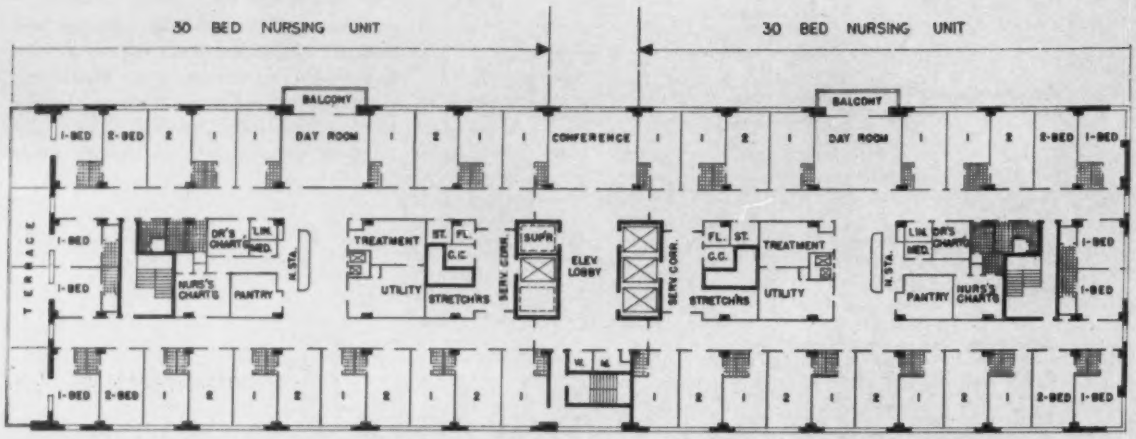
The hospital has a wide range of communication facilities. They include two double batteries of dumb-waiters, one on each side. Each battery has one dumb-waiter large enough for carts which will convey supplies from central medical-surgical supply and central storage units to all the nursing floors. The other will carry trays from the same sources. A vacuum tube communication system with outlets in all nursing units and in all departments



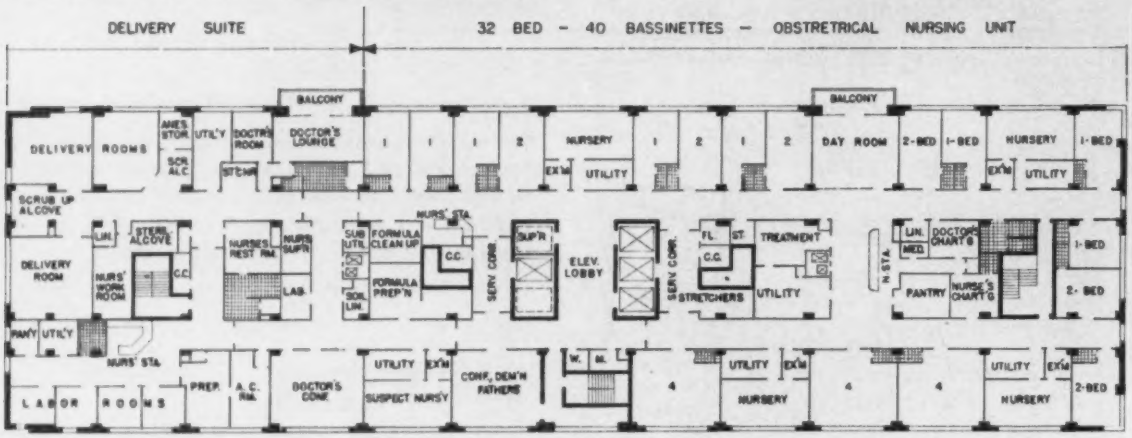
Plan of the first floor, which contains, in addition to the usual administrative and business offices, the operating room suite and eight-bed recovery unit. This allows for expansion without disruption of other services and permits expeditious handling of accident and emergency cases.

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Certificates have been presented to the hospital, architects and state officials. A similar award will be made by The Modern Hospital each month.

Ground floor. All services, such as kitchen, dining areas, laundry and power plant, were designed for the maximum capacity of 500 beds. Laboratories and the communication center, storage areas and employes' lockers are on this floor.



The fifth floor (above) contains two 30 bed private nursing units, each with two-bed and one-bed rooms exclusively. These units will be used for both medical and surgical cases.



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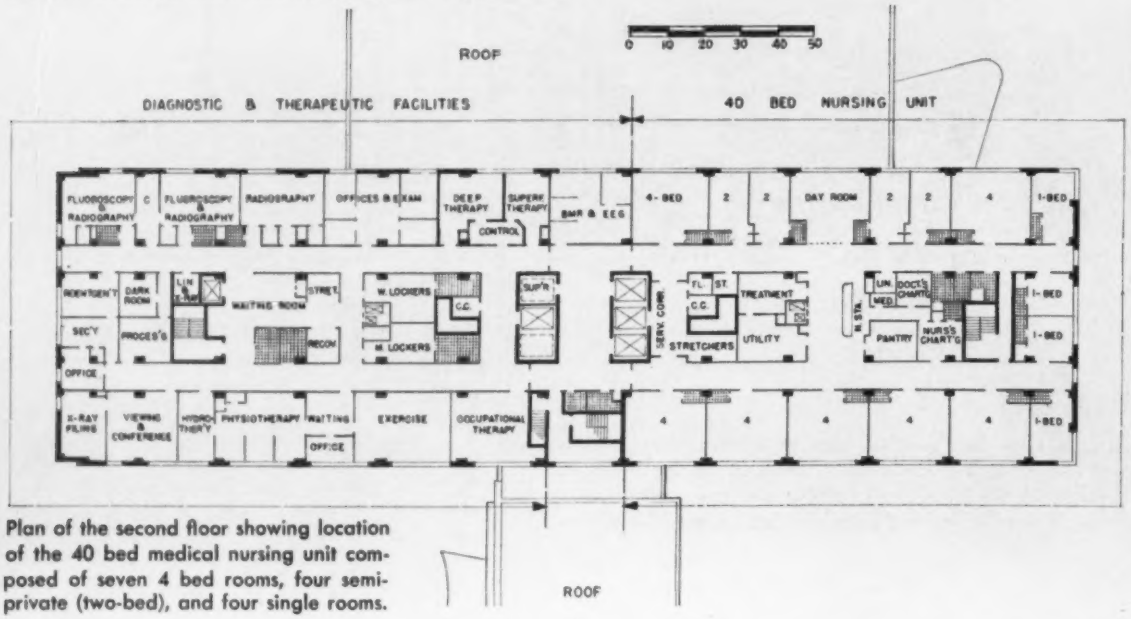

Plan of the second floor showing location of the 40 bed medical nursing unit composed of seven 4 bed rooms, four semi-private (two-bed), and four single rooms.

STATISTICAL ANALYSIS

514 Bed, 3 Phase Building Project

PHASE I	Cubage (Cu. Ft.)	Construction Costs (Includ. Fixed Equipt., Arch. & Eng. Fees)	Cost Cu. Ft.	Cost/Bed (Excl. of Bassinets)	Additional Costs	
Main Building (214 beds)	2,287,000				Port. & disp. equipt. & furn.	$490,000
Utility building	83,000				Landscaping, gardening	88,000
					Administration, etc.	43,000
	2,370,000	$4,942,000	$2.08	$23,094		$621,000
PHASE II (To be completed in 1954)						
Laundry	78,000	192,000	2.45		Port. & disp. equipt. & furn.	$110,000
House staff residence	165,000	206,000	1.25		Miscellaneous costs	20,000
Premature nursery center	83,000	186,000	2.25			
Auditorium	162,000	243,000	1.50			$130,000
	488,000	$ 827,000	$1.70			
TOTAL PHASE I & II	2,858,000	$5,769,000	$2.02	$26,958		$751,000
PHASE III (Estimated)						
4 additional floors (300 beds)	904,000	$1,718,000	$1.90		Port. & disp. equipt. & furn.	$410,000
Expanded O. R.	42,000	105,000	2.50		Miscellaneous costs	75,000
Expanded laboratories, OPD-Diagnostic services	270,000	675,000	2.50			$485,000
Expanded utility building	24,000	48,000	2.00			
Expanded admin. wing	17,000	25,000	1.50			
Expanded house staff resid.	100,000	125,000	1.25			
	1,357,000	$2,696,000	$1.98			
TOTAL PHASE I, II & III	4,215,000 cu. ft.	$8,465,000	$2.01	$16,469		$1,236,000
						8,465,000
					TOTAL PROJECT COST	$9,701,000

will have its central relay point at the record room site.

A wired telephonic device located in all the nursing stations, in the operating and delivery suites, and in the outpatient examining rooms will enable doctors and nurses to dictate postoperative, preoperative, follow-up, and history and physical records to a central secretarial pool where they will be transcribed. This device is also available in the morgue and in the laboratories. Transcribed reports are returned to point of origin via the vacuum tube system. A conveyor belt system connects the central supply unit to the operating suite. It makes it possible for all packs, trays and instruments to be made up in central supply and delivered swiftly to the operating suite, thus relieving the nurses and ancillary personnel for purely surgical services. The only sterilizing facility provided on each nursing floor is a bedpan washer and sterilizer. All other sterilization is done in central supply, thus enabling the nursing staff on each floor to give more time to purely nursing duties. The system also assures closer control of sterilization technics.

The first construction stage provides for four elevators placed in a bank with the service elevators opening onto service corridors and the patient and visitor elevators opening onto the central corridor. Shafts are provided for two additional elevators to be added when the hospital structure is increased by four floors.

Intercoms have been provided for use within all departments and between all departments, thus relieving the telephone switchboard of a good part of the heavy burden usually placed upon it. Nevertheless, all telephones are interior dialed and will be used to supplement the intercom system.

WILL USE RADIO PAGING

The Long Island Jewish Hospital will be the first in this country to replace the conventional loud-speaker or light signal paging system for doctors with an ultra high frequency radio paging system. The new system makes possible instantaneous, noiseless and specific paging. It consists of a central broadcasting unit and small radio receiving sets. Before going on his rounds each doctor will pick up a portable receiver only 2 inches longer than a pack of king-sized cigarets and only slightly heavier. The set fits easily into the breast pocket of the jacket or may be clipped on a belt. Each receiver is set to pick up one particular ultra high frequency signal that is effective over a 3 mile radius. When a doctor is wanted, an operator at the central keyboard sends out a high-pitched signal which can be readily heard only by the person being paged. Approximately 850 different signals can be sent out through the keyboard. The new system will not disturb patients and makes it possible to get in touch with persons who are on the move or in adjoining buildings on the hospital site.

The final total cost of the Long Island Jewish Hospital, exclusive of the anticipated 300 bed expansion costs, but including construction, all fees, furnishings, Class I, II and III equipment, the house staff residence for 56 physicians, the premature nursery center, auditorium, and laundry is estimated at $6,500,000. This represents a cost per bed and bassinet of $22,100. When the additional four floors are added and the operating suite, the outpatient department, laboratory and diagnostic services are expanded, the total cost per bed, it is anticipated, will be reduced to approximately $16,500.

Standardization as a Tool for Better Care

How the nursing service can plan—and profit by—a program of standardization

MARGARET K. SCHAFER
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Public Health Service, Washington, D.C.

THE successful interchange of personnel among the units of a hospital is dependent upon standardization of procedures and physical facilities.

Every hospital has some form and degree of standardization familiar to all of us. Meals are served to patients at stated hours, surgical operations are scheduled on certain days, certain reports and records are maintained, and procedures such as taking patients' temperatures are done at stated intervals, according to a definite procedure or routine.

In industry and commerce standardization has increased and improved production, eliminated waste, increased the efficiency of the worker, improved products, and reduced costs. In a hospital it is a tool to promote good patient care, reduce cost, eliminate waste, increase the efficiency and satisfaction of personnel, and foster order and harmony.

The three prerequisites of standardization are: (1) a standard, (2) law or authority, and (3) general acceptance.

The first requisite for standardization is to establish the standard, which is a rule, a model, or guide that can be used as a criterion.

Standards are established by persons in authority, or experts in the field. Simplification, which usually precedes standardization, eliminates, combines and improves types, grades or kinds of items. Then when practices are established on the remaining items uniformity results. Before uniformity can become standardization a standard must be developed and used.

Standards should not be formulated by one person, but should represent the thoughts and ideas of a group, with the best current knowledge and experience available being utilized.

The second prerequisite for standardization is to have the administrative authority express a desire or issue the required instructions that standardization will be adopted and practiced. Law by its very nature is a last report in standardization. Education, training and mutual cooperation are desirable, but in some instances compliance may be not only advisable but necessary to protect health, welfare and safety or to reduce costs.

The third prerequisite is that standardization must have the general acceptance of all concerned: management, labor and the consumer. In the hospital there must be acceptance by the administrator and professional staff, the hospital personnel, the patients, and the public. Acceptance is based on a knowledge of the direct and indirect values of the practice. The hospital administrator wants to be assured of good patient care with minimum expenditure of personnel time and materials. He also is interested in a smooth running organization without friction or confusion. The physicians, nurses and other personnel caring for patients are interested primarily in providing quality patient care. They are usually willing to cooperate in any hospital routine that will expedite their work. A demonstration of the necessity and value of standardization is sometimes necessary to assure acceptance and compliance. Each employe wants to be assured employment, adequate salary, and satisfactory working conditions. The patient and public must be assured quality care, with personal consideration and safety at a reasonable price.

The basic requirements of a standard are that it shall be accurate and precise, workable, suitable, flexible and acceptable. A standard must be accurate and precise and based on the best research and information available. However, except when exact criteria are absolutely necessary, requirements should not be set so high that they cannot be followed under existing or attainable circumstances. A standard to bathe bed patients daily may be desirable, but with very limited personnel it might not be considered the correct standard. It might be better not to be so precise but to allow some leeway and state that bathing should be at least every other day—preferably every day.

A standard may not be workable owing to something about the standard itself, or to outside conditions which influence its workability. A standard to sterilize syringes in a hot air sterilizer, for example, would not be workable if that type of sterilizer were not available. A standard could be correct, accurate, precise and workable and still not be suitable because of changing conditions. What was considered good practice yesterday may be considered unsuitable today. Sterilizing syringes by the boiling method was considered good practice a few years ago, but now it is advisable to sterilize them with steam under pressure or with dry heat.

Also, a standard may be suitable for one area and not another. A standard for a 6 cubic foot refrigerator may be suitable for the infant formula room in a 100 bed hospital, and be unsuitable for a formula room in a 50 bed hospital. Sometimes modification must be made in setting up standards to make them suitable in order that they will fit in with other standards. The standard for the size of a certain room may have to be changed to allow suffi-

Condensed from a paper presented at the Seventh Interagency Institute for Federal Hospital Administrators, November 1953, Walter Reed Army Medical Center, Washington, D.C.

cient space for the equipment required within the area.

By making the scope of a standard as broad as possible, greater flexibility is obtained. Sometimes alternate methods may be specified, but it is often necessary to limit the scope, inasmuch as too much flexibility may destroy the value of the standard. A standard may be written for taking patients' temperatures which would provide for the oral, rectal or axillary method.

A standard may be correct in all known aspects, but unless it is acceptable it is useless and cannot be used for standardization. The reason for nonacceptance may be something within the standard, or it may be the people concerned. The best way to gain acceptance is to have the groups or individuals concerned with the application of the standard participate in its formulation or selection. In this way better standards result, suspicion and resentment are minimized, and compliance is enhanced. Also, in the hospital every effort must be made to assure the personnel that continuous and improved service will be assured without confusion or inconvenience.

TYPES OF STANDARDS

The basic types of standards are: (1) work, (2) procedures, (3) buildings, (4) equipment, (5) products, and (6) conditions.

Work standards can be set up for machines or men, or for men operating machines. Work standards for men are determined by the ability and training of the worker and the job to be done. A work standard for a man operating a machine is governed by both the man and the machine. An example of a work standard for a man would be the number of patients a nurse should care for on a certain nursing unit or the number of needles to be cleaned per day by a worker in the central supply room. Two different standards could be established for workers cleaning needles, one for an all manual operation and the other for an operation using a needle cleaning machine. Such standards are governed by human capacities, training and the tools supplied.

Procedure or methods standards describe the particular way of doing something. These standards usually outline a routine by steps. Hospital procedures include patient care, supply and equipment, service and management. They are governed by the purpose of the procedures and the conditions under which they are applied.

Equipment or tools standards include the things that are required for various procedures. Surgical instruments and gauze dressings are examples of equipment and materials that lend themselves to standardization.

Products in a hospital are the services to patients, but there are also many other products including food, supplies and records. We react unfavorably to the thought of standardizing anything pertaining to patients or personnel, but actually a quality standard of patient care is our main goal.

The conditions or environment within a hospital are phases of standardization which are most desirable and necessary. Although standardization of conditions includes some of the other areas of standardization, such as equipment and procedures, the primary factors are temperature, ventilation and the arrangement and location of equipment and supplies. Medical and

(*Continued on Page* 78)

Good nursing service is built upon

A Sound Program of Nursing Education

MIRIAM D. RAND, R.N.
Director of Nursing, Passavant Memorial Hospital, Chicago

WITHOUT good nursing service there can be no good nursing education. I believe I can say as confidently that good nursing education improves nursing service.

No matter whether the program to educate nurses is carried out in one, two, three, four or five years, there are some factors essential for a good school of nursing. A good school of nursing must have the support of and be guided by a governing body and administrator interested in the progress in knowledge and skill of the students. The philosophy of the school must be in harmony with that of general education and democratic practices.

It takes funds to operate a good school of nursing. I suspect if it were not for economic factors there would be little delay in putting into use the best educational practices which have been developed.

A field of experience must be provided where learned principles can be applied in patient care. Hospital administrators guard the entrance to that field of experience. The hospital is the only place where a student can really become a nurse. Hospital wards are valuable as an educational facility. It seems to me that hospital administrators have hesitated to put a value on this unique area. We should not be too reluctant to charge fees for a good educational program. It is a common practice in America to pay well for a commodity of fine quality which is really desired. It is doubtful if a student can pay for her entire education by service to patients in a program which has as its purpose the education of a nurse and the development of a young woman capable of taking her place in present day society.

I have already said that behind any educational program there must be a controlling body interested in the curricular aims and familiar with its achievement. In hospital schools of nursing the administrator has the same responsibilities that the dean has in a university or college. Any young woman who spends three or four years of her life at school deserves to receive something other than an accumulation of cold facts. We should recognize the need for a well trained faculty. The teachers must be qualified to direct the lives of young women entrusted to their care. Attitudes must be molded, information must be imparted, and skills must be supervised.

More than ever today, with the growing need to provide care for psychiatric patients in general hospitals and with the increasing impact of psychosomatic medicine, do nurses need sound background in the social sciences. As the hospital attempts to

(*Continued on Page* 146)

Presented at the 21st Chicago Institute for Hospital Administrators, University of Chicago, September 1953.

nursing personnel should be able to give more and better patient care when they are working in an orderly healthful environment and have the necessary supplies and equipment kept in a standard orderly fashion.

The first step in planning and initiating a standardization program for the nursing service is to appoint a committee and a chairman or director of the program. The committee should include representatives of all departments providing patient care, or furnishing supplies, equipment or services to the patient areas of the hospital. These committee members will vary with the areas being standardized. It is wise to keep the group small and expand it when projects warrant a larger group or different persons. It is also helpful to appoint subcommittees or task committees to draft proposed practices, or check on areas requiring research, consultation or experiment.

Although joint planning is desirable, one person must be appointed to have the primary responsibility for planning, collecting information, spearheading studies and decisions.

HOW TO DEVELOP PROGRAM

Two methods might be used to develop and introduce the program. One method is to employ an expert to conduct a study and work out the program. Disadvantages of this method are that there may be difficulty in finding the person qualified to do the job, the cost may be prohibitive, and it is sometimes difficult to establish and maintain rapport between the outside specialists and the hospital personnel. The other method is to have the program developed by the hospital personnel. The value of this method is that there may be better acceptance. The problem is that it may be difficult to find the persons qualified to do the job owing to their limited vision, and unless relief is given from regular operational responsibilities, the individuals may not have sufficient time. A combination of the two methods may also be used.

A few hospitals have carried out detailed research programs which have produced data for improving procedures, facilities or equipment. Any hospital can work out a standardization program with its own personnel and without special funds. The following procedure could be used:

If possible, relieve the chairman of the standardization committee of some of her regular hospital duties. Have her start on one nursing unit, and set it up as a demonstration unit to be used as the standard. After the program is established on this unit, standardize the rest of the units.

Basic to developing a program are a definition of objectives, a list of the areas and what is to be standardized within each area, and then a decision as to how to carry out the program. The committee should also review pertinent standards developed by individuals or groups outside the hospital. These standards may be recommendations for desirable operation, requirements for approval or accreditation by a professional organization, or criteria for compliance to a law or regulation.

Areas within the nursing department where standardization should be considered are: (1) work; (2) procedures; (3) physical facilities, including equipment and supplies, and (4) conditions.

For each of these areas the criteria for standardization include volume of quantity, repetitive operations, number of people, quality of variables to be controlled. Although there is no order in which the program is developed, the logical order is first to develop the work and procedure standards, and base the physical facilities, equipment and supplies and working conditions on the procedural needs. In actual practice all four of these areas are so interrelated that their development might well take place concurrently.

To establish standardization of nursing procedures the following steps could be adopted:

1. Prepare a list of all procedures performed on each unit of the hospital and group them under the following headings:
   (a) Patient care
   (b) Supply and equipment
   (c) Service
   (d) Management.
2. Check the list with any existing procedure and policy books.
3. Review reference materials and standards recommended for the specific procedures by professional groups, accrediting agencies or governmental authorities.
4. Prepare a suggested outline for procedures not included in existing procedure books.
5. Consult with the committees and other individuals concerned about the addition or changes indicated. Whenever it is possible, eliminate, consolidate and simplify.
6. Prepare a draft of revised procedures.
7. Have the recommendations reviewed by as many people as possible, or advisable, who are in a position to give constructive suggestions, or who will be affected by the changes.
8. Obtain administrative acceptance from the hospital authorities through the director of nurses.
9. Prepare a procedure book or card file of all procedures.
10. Orient all personnel to the new standards and when indicated demonstrate the newly established procedures.
11. Follow through and revise at stated intervals or whenever necessary to keep the standards current and workable.

On the basis of the procedures adopted, the supply and equipment standards to carry out the procedures can be developed.

Standardization of supplies and equipment includes type, amount, preparation and care, location and arrangement. When standards for types of supplies and equipment are established, it is suggested that whenever possible recommendations of simplified practice, commercial standards, and federal specifications be used.

EFFICIENCY BRINGS SAVINGS

Although supply and equipment needs are based on procedures, in actual practice procedures are often simplified, standardized and improved by the supplies and equipment available. The area of supply and equipment lends itself well to standardization and simplification. Industry has found it can do little to control the cost of labor or raw materials. It is through efficient operation and utilization of men and materials that savings and increased efficiency result. No one likes to think of standardizing patient care, but the handling and care of materials increases over-all efficiency and ultimately affects patient care. Hospital central supply departments promote standardization.

Suggested steps in standardizing supplies and equipment kept on a unit would be:

1. Prepare a list of supplies and equipment required on the unit for patient care, management and housekeeping functions.
2. Determine the frequency of use.
3. Determine amounts used for a

(*Continued on Page* 144)

Goods move with speed and dispatch at Lowell because they put

Central Supply at the Crossroads

PAUL J. SPENCER and WALTER V. COBURN
Director and Administrative Resident, Lowell General Hospital, Lowell, Mass.

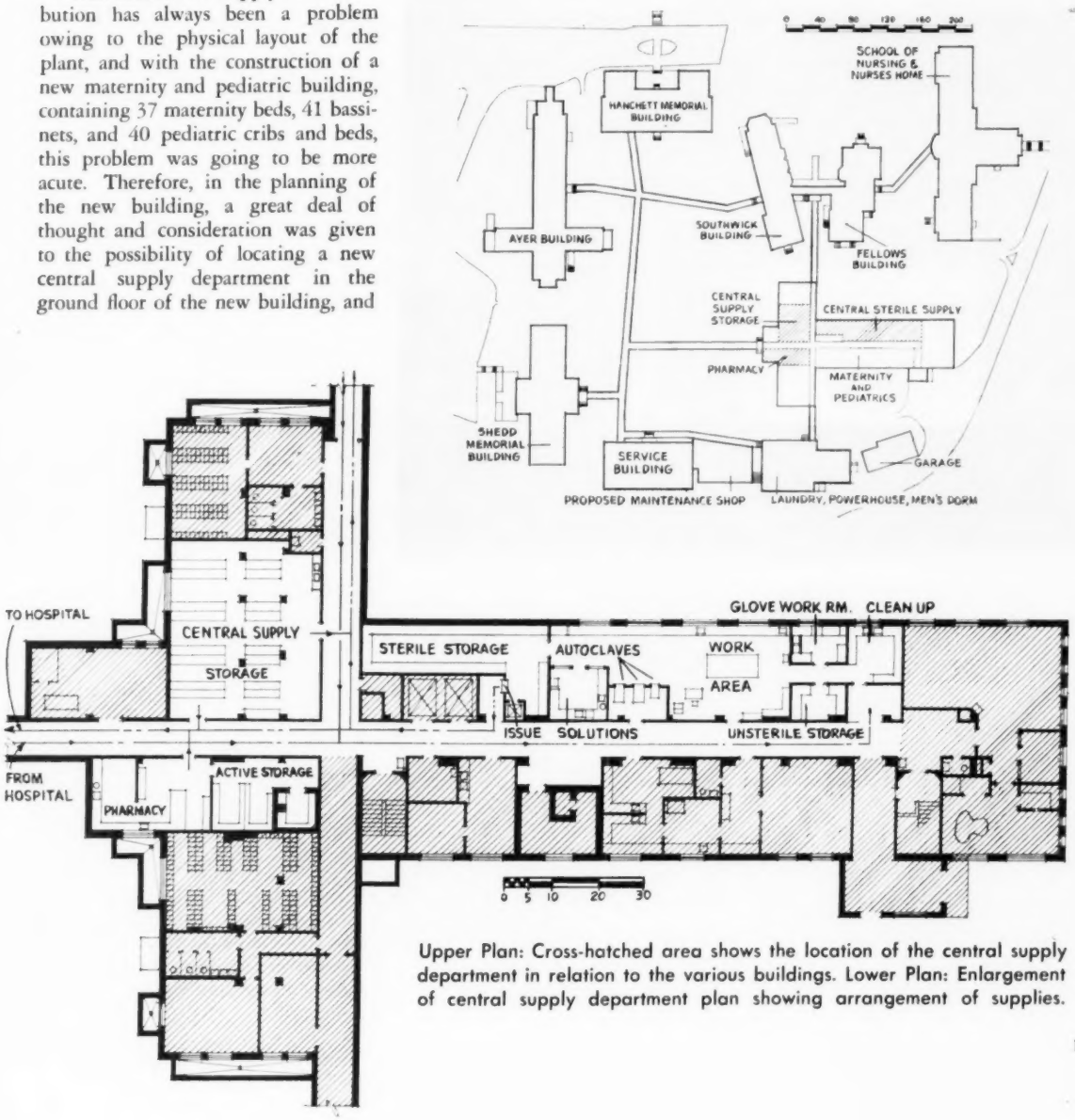
DONALD RITCHIE
Architect, James H. Ritchie and Associates, Boston

THE Lowell General Hospital, Lowell, Mass., is a campus style of hospital of 257 beds, with all of its buildings forming a quadrangle and connected to each other by underground tunnels.

Centralization of supply and distribution has always been a problem owing to the physical layout of the plant, and with the construction of a new maternity and pediatric building, containing 37 maternity beds, 41 bassinets, and 40 pediatric cribs and beds, this problem was going to be more acute. Therefore, in the planning of the new building, a great deal of thought and consideration was given to the possibility of locating a new central supply department in the ground floor of the new building, and this course was finally adopted since the issuing of virtually all supplies could then be concentrated in one building, and because the distance of travel from this point would be about equidistant to all other buildings in the hospital proper.

Forty-five hundred square feet of floor space was made available for

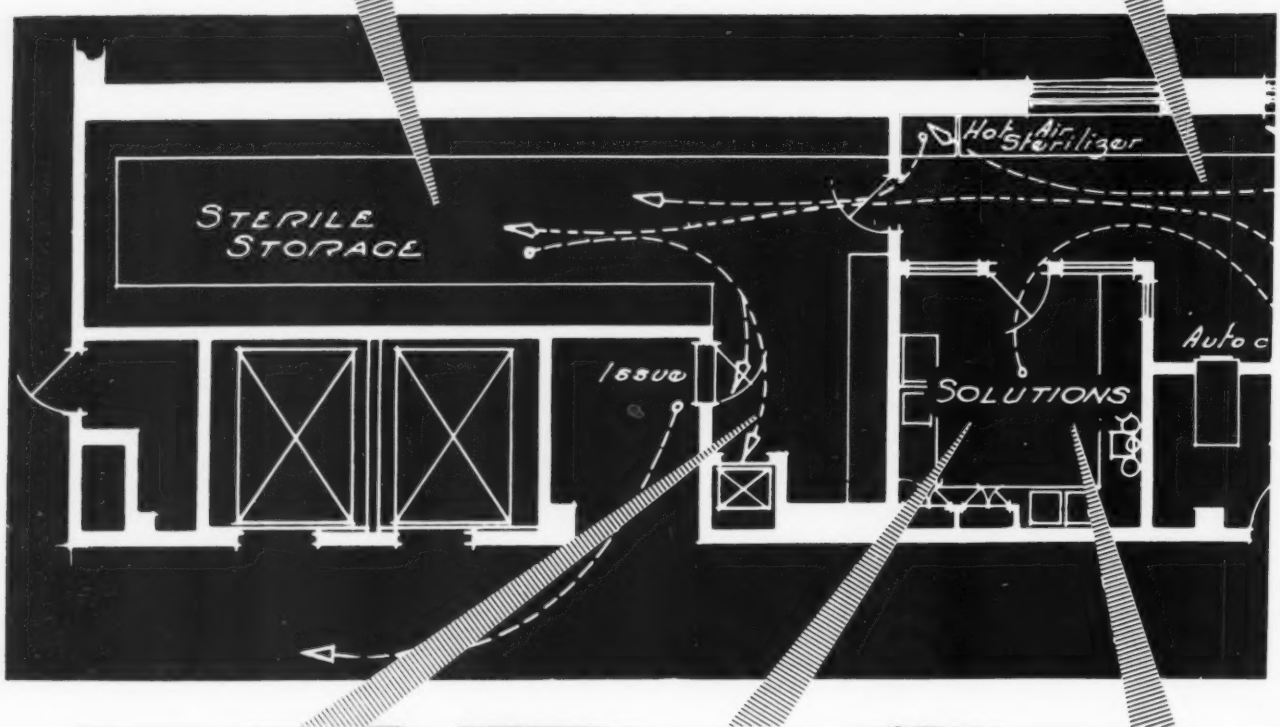
(*Continued on Page* 82)



Upper Plan: Cross-hatched area shows the location of the central supply department in relation to the various buildings. Lower Plan: Enlargement of central supply department plan showing arrangement of supplies.

Portion of sterile storage. I.V. nurse in foreground checking her chart. Shelving will allow for expansion.

General view of the central supply workroom. Below: Diagram of the traffic flow in and out of the area.



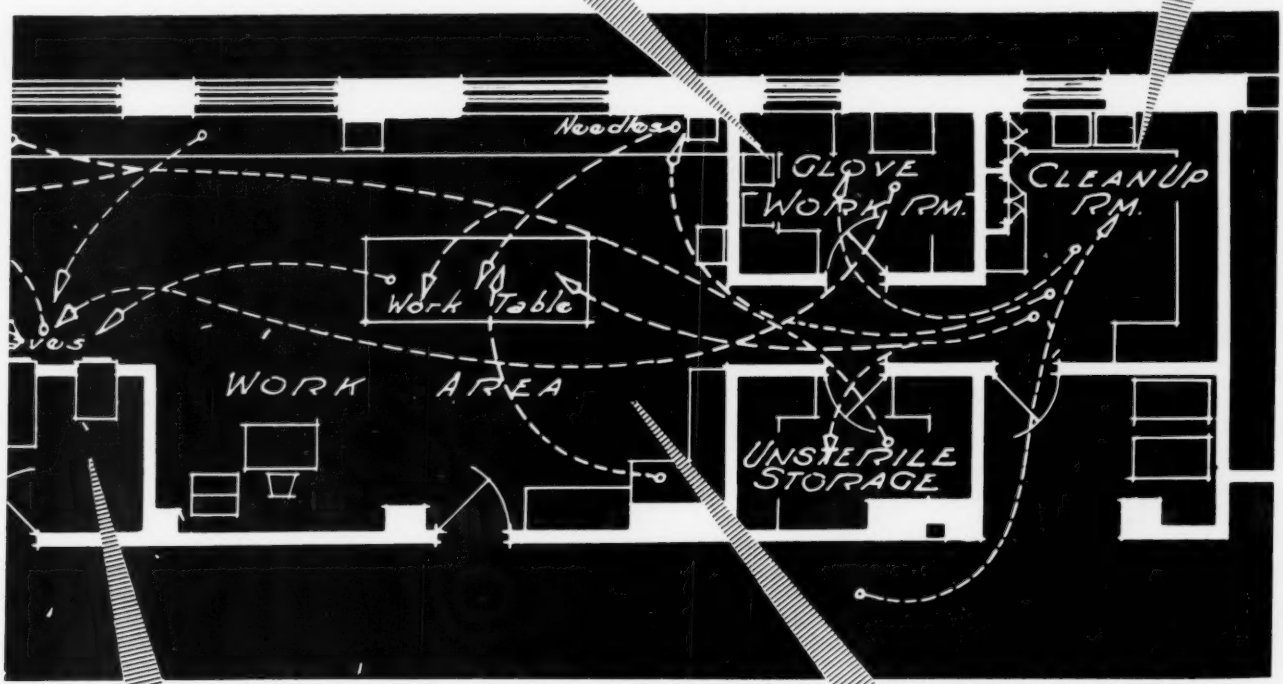
C.S.R. employe filling dumb-waiter while a floor nurse waits for service.

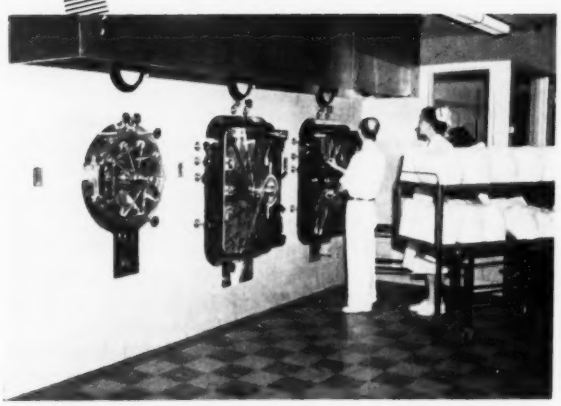
The solution is withdrawn from the mixing valve and flasks are filled.

Flasks are rinsed in distilled water. Right: Removing flasks from washer.

The glove room, showing (left to right) glove tester, drier and powder machine, and washer for 50 pairs.

In the receiving and clean-up room utensils are washed and the linen is removed for pick-up by the laundry.





Sterilizer bank, hot air sterilizer not shown. Glass on right side is partition to solution manufacturing room.

General workroom. In foreground, the supervisor arranges trays with pictures for the student nurses.

pharmacy, general stores and central sterile supply, and the accompanying floor plan illustrates the manner in which the issue of goods from these three main divisions of central supply centers on the intersection of the corridors and the tunnel system.

The central sterile supply and workroom is the heart of this entire unit and adjacent to it are the storage areas for issuance by delivery truck of all goods and equipment for patient departments.

The "General Stores" room includes everything from paper and pencils to dishes and x-ray film. Across the hall from it drugs and pharmaceuticals are dispensed. The active storage, connected by a locked door from the pharmacy proper, houses narcotics and alcohol in a special vault with combination safe doors. The vault storage, of course, conforms with the requirements of the Alcohol and Tobacco Tax Division of the Internal Revenue Service. All pharmacy issue is over a Dutch door with special counter top surface.

ROOM FOR OXYGEN STORAGE

The oxygen manifold room, houses 2 four-tank units in addition to retaining wall chains for 12 additional tanks. Oxygen piping is constructed in this new building only, and is restricted to the delivery room area, certain nurseries where frequent use is indicated, and to the admitting and isolation section of the children's floor. Charges for piped oxygen are computed by use of metering devices recently placed in service. Oxygen for storage is received at the ambulance entrance. This latter entrance is designed primarily for physical therapy outpatient traffic and admission of ambulance cases for this building's services.

The equipment storage room houses oxygen tents, suction and drainage apparatus, and centrally stored equipment issued to all nursing units within the hospital. An orderly on duty in this area receives and delivers the apparatus stored here, and is also available for use in physical therapy when there are heavy patients to be lifted. He inspects and changes oxygen tanks in the oxygen manifold room and when free time permits assists in central sterile supply.

Goods returned to central sterile supply are received only via a truck alcove adjacent to the clean-up room. In the latter room utensils are washed, linen is removed and set aside for laundry pick-up, equipment is sorted and washed or forwarded to the appropriate area in the workroom. An automatic syringe washer is part of the facilities in this area. Washed, unsterile items not for immediate processing are placed in unsterile storage. Opposite is the specially designed glove room, where all rubber gloves for the hospital are washed, dried, inspected, powdered and packaged for autoclaving. The work here is handled mechanically as far as possible and we are utilizing a glove washer, drier and conditioner combination and a glove tester.

PHOTOGRAPHS AID TRAINING

Moving into the work area, goods receive a final processing, needles are mechanically washed and inspected, and trays, packs and other typical sterile goods are packaged for autoclaving. To assist in the training of personnel in this department the hospital has taken photographs of "setups" which are enlarged to 8 by 10 inch size. These pictures with descriptive listings of items contained on the trays speed the work of new employes.

Goods prepared for autoclaving move to the bank of sterilizers located at the opposite end of the long workroom. We have installed three recessed autoclaves, two rectangular 48 inch and one cylindrical 20 inch, to handle sterilizing of all goods other than those that must be specially handled in the electric hot air sterilizer located opposite the solution room. The autoclave room, readily accessible from the outside corridor, permits easy maintenance and houses the stills which produce distilled water piped to the three 12 gallon reservoirs in the solution manufacturing room.

Solution manufacturing is new with Lowell General Hospital and it was after thorough investigation and study that the decision was made to manufacture all parenteral fluids. This area is under the professional supervision of our pathologist, and the complete facilities plus good, well indoctrinated personnel have provided the hospital with an opportunity for real savings. Sterilization of solutions takes place in the 48 inch autoclave next to the manufacturing room reserved for that usage alone.

Together with newly sterilized supplies, the solutions progress to the sterile storage section. Banks of shelving line the walls of this spacious area. Access to upper shelves where items of less frequent usage are stored is gained by aluminum stepladders, one of conventional type and one on wheels.

Completing the flow of work, the sterile goods are issued from the storage area. Delivery to all floors in the new building, including the labor and delivery suite, is accomplished by using the electric dumb-waiter. Truck and light aluminum delivery carts forward sterile supplies through the tunnels to the other buildings in the quadrangle.

The flow of work has been made as intelligent as possible; the working conditions, equipment and apparatus are as complete and modern as any available. Ventilating and air conditioning treatment are the finest procurable. All rooms in the building have individual thermostatic controls to meet the occupants' desires, and in areas where controlled humidity is important, individual humidity regulators are also provided. Great attention has been given to the flexibility of the various areas into which central supply has been segmented in anticipation of future expansion of services.

At the moment we are still sterilizing packs and instruments for the operating room suite in facilities on the operating room floor. However, we envision incorporating this into the central sterile supply in due course. We hope to have all supplies (except foodstuffs) emanate from the new area.

UTILIZED BEST FEATURES

The planning for central supply was spread over a period of about two years during which time the architect and his consulting engineers, together with various hospital suppliers, met with the pathologist, administrative and central supply personnel, members of the medical and nursing staffs, and the purchasing agent to make certain that professional and technical procedures, plus all necessary facilities and equipment, were incorporated. Many trips were made to other hospitals over a wide radius and we attempted to utilize the best features observed.

Like so many things, this area must really "be seen to be appreciated." The adjustable stainless metal shelving, bins, counters, sinks, cabinets, together with fluorescent lighting, tile dadoes, asphalt tile floors, and all other appurtenances bespeak attention to an efficient medium for operation with a minimum of maintenance. In addition, acoustical ceilings, attractive painting and a great sense of space, yet segregation, all give the personnel pride and pleasure.

FRANK BRADLEY, M.D.
C. O. VERMILLION, M.D.
WILLIAM ANDERSON

The machine principle of statistical analysis offers many advantages which are explained in this discussion of one hospital's experience with

Medical Records on Punch Cards—II

IN THE first section of this article, which appeared in the April issue, we described the technic employed at Barnes Hospital, St. Louis, of setting up a diagnostic cross-index on punch cards, using the "Standard Nomenclature of Diseases and Operations."

Other applications of punch card methods to the preparation of medical records include: source materials for a diagnostic index, operations index, physicians' index, cross-diagnosis file, and cross-reference file. Because of the combination of all of this information on one card, the files did not exist in actuality inasmuch as the cards were not filed in any particular order. It would be possible to file these cards according to any method desired.

The most logical file would probably be in numerical order of primary diagnosis; however, when the cards were used for any other study, the order would be so disturbed that it would then be necessary to rearrange them in numerical order of primary diagnosis. For this reason, our filing is only by calendar year and by the various hospitals in this center. When any specific study was desired, it was therefore necessary to run all of the cards through a sorter which would separate out those wanted.

The great difficulty in this connection was the excessive number of cards that must be run through the machine for each condition studied. For a study of the occurrence of any specific condition during a five-year period in Barnes Hospital alone, it was necessary to run more than 60,000 cards through the sorter. This was further complicated by the fact that the diagnosis might be listed in any one of the four different diagnostic fields or an operation in any of the three operation fields. Thus the cards would have to be run through the machine three or four times, searching a different field on each run.

This problem was simplified with the introduction of a machine which would search different fields upon a single run, but the procedure was still extremely time consuming and expensive. Of course, these listings would be saved for future studies, but, even so, they were of little use because studies were only rarely duplicated.

Once the cards were selected, it was very easy to use them for various statistical studies, such as analysis of the length of stay, condition on discharge, age, sex and race incidence, and so forth. However, the difficulty of original selection of the desired cards led to an impractical situation where such a search would have to be extremely important in terms of value produced in order to justify the expenditure of manpower and machine time required. One might question the value of punch card recording of such diagnoses when this bottleneck interferes with obtaining any studies from the tremendous volume of cards.

Two methods have been used to overcome this difficulty. Both of these require key-punching a separate card for each diagnosis and operation. The simplest system records only one diagnosis or operation per card. If these are filed in numerical order, such as an ordinary diagnostic index, it is easy to obtain those desired. The simultaneous occurrence of two specific entities is also relatively simple by comparing the two sets to find the ones that have some common identification, such as registration number

The authors are, respectively, director, associate director and controller of Barnes Hospital, St. Louis.

This is the second section of the article on punch card methods of preparing medical records. The first section appeared in the April issue of The Modern Hospital.

or unit history number. For other studies however, such as all other disorders occurring with any specific disease or operation, it is most practical to refer to the actual medical records.

A second method, which is in use in some institutions, requires a separate card for each diagnosis, but all other diagnoses are recorded on it. The order on one card will be the same order as the theoretical importance of the diagnoses recorded, that is, 1, 2, 3 and 4 for a record with four diagnoses. The second card would then have the diagnoses key-punched in the order 2, 3, 4 and 1; the third one in the order 3, 4, 1 and 2, and the fourth one in the order 4, 1, 2 and 3. These cards can then be filed in numerical order of diagnostic code number in a complete diagnostic file. Therefore, one card for each diagnosis is available for the different sections of the file, each card having the other diagnoses on it also. This method is more advantageous for cross-index and cross-reference studies.

MANY CARDS NEEDED

Several difficulties are encountered with both of these systems. One problem is the great number of punch cards that are necessary. This not only increases expense in terms of both operator and machine time, but also requires an increased amount of storage space. A brief analysis of samples of our records showed that such systems would require an average of more than three cards per record. In many institutions there are so many diagnostic cards that their value has been seriously questioned because of the amount of storage space necessary.

The most practical system we have found for punch cards consists of a filing cabinet occupying about 4 square feet of floor space and of slightly more than 4 feet height for each 70,000 cards. For an institution with approximately 20,000 admissions per year, such a cabinet would hold the cards of three calendar years with a system such as ours of using one card per patient with trailer cards when necessary. For the systems that require one card per diagnosis or operation, one cabinet would only contain the cards for one year's experience. Although most studies are limited to recent years and approximately five-year intervals, there are occasions when the entire experience of the institution is needed for a statistical study. It can thus be seen that at least five or 10 years' cards must be kept readily accessible, or the value of the cards is greatly diminished. If they are placed in dead storage, they are almost useless.

The extra personnel time in key-punching a separate card for each diagnosis is more than would be expected because some time is involved by the key-punch operator's having to recognize a different order of listing of the various diagnoses for each card key-punched.

Because of the problems inherent in the various systems known to us, we sought a method of actually achieving a cross-diagnosis file from our style of punch cards. After considerable study, this was accomplished by the use of punch cards to produce a listing which showed all information on the card. This listing is in numerical order of code number of the primary diagnosis for all cards of a given group (one calendar year was selected for such a group). This was only part of the task because the diagnosis sought might be in the second, third or fourth field instead of the first. It was therefore necessary to re-sort the entire group of cards, rearranging them in numerical order of the code number of the diagnosis in the second field and listing them again in this order, eliminating, of course, any cards which did not have any diagnosis coded in the second field.

This group of cards was then re-sorted into numerical order of the code in the third diagnosis field and again listed after elimination of the cards with no diagnosis in this field. It is of interest to note here that on the second list, that of numerical order of code number in the second diagnostic field, several entries were recorded in which there was no diagnosis in the primary field. These represent the "trailer" cards referred to heretofore and were identified as being "trailer" cards in this same way. With this exception, all entries in the second, third, and fourth listings will also bear code numbers in the previous columns. This would not be necessary for a diagnostic file alone but is necessary for a cross-index.

An illustration of the use of these lists may be in order. For any given diagnosis, such as acute lobar pneumonia, it is necessary only to look for the appropriate code number, in this case, 360-100, in each of the four listings. This would indicate the various medical records that were to be pulled for inspection if desired. If it was desired to check the coexistence of one or more other conditions, it would merely be necessary to see if these other code numbers appeared in some other field of the entries established as being pertinent by their identification, *i.e.* by code No. 360-100.

By using exactly the same mechanism, based upon the three fields for operations, it was possible for us to achieve a listing which, in essence, was an operative index with cross-reference to other operations performed or to the various disorders of the patients who had these operations.

MADE ROOM FOR EXPANSION

With the publication of the fourth edition of "Standard Nomenclature of Diseases and Operations," we found that a high percentage of the medical code required eight digits instead of six and most of the operations code required seven digits instead of six. It was therefore necessary to delete some of the information that was originally on the punch card to expand the fields for diagnosis and operation entries. More specifically, elimination of 11 columns of information previously carried was necessary to provide two additional columns for each of the four diagnostic fields and one additional column for each of the three operation fields. Nine of these columns were obtained by omission of five columns previously assigned to the patient's discharge date, two columns indicating number of admissions of the patient, one column for marital status, and one for private, semiprivate or ward status. The two remaining columns needed were obtained by the columns used for unit history number being reduced from seven to six and the columns used for number of days' stay from three to two.

For statistical analysis of various disease entities, such a listing as we have described is not too valuable by itself other than as source material. Whenever the investigator desires to refer to the medical records themselves, this listing is quite helpful. On other statistical studies of age, sex or race distribution, or coexistence of other disease entities, the information is readily obtained from the listing by direct extraction in case the number of entries studied is not large. If, however, the entries are numerous, it has been found best to key-punch new cards from the entries in this listing. These cards can then be sorted and classified in any method desired ac-

(*Continued on Page* 150)

Practitioners Seek Hospital Privileges

"Open every hospital to family doctor," G.P. asks in address to academy

CLEVELAND.—Every hospital in the country should be open to the general practitioner, and every patient should be under the supervision of a family doctor, Dr. Fount Richardson of Arkansas declared in an address to the congress of delegates of the American Academy of General Practice, in session here last month at its sixth annual assembly.

Dr. Richardson urged revision of hospital standards by the Joint Commission on Accreditation of Hospitals looking toward the achievement of these objectives.

Following Dr. Richardson's address, delegates approved a resolution to the effect that every family should have a family physician with whom fees, referrals, specialist consultations and limitations of practice may be freely discussed. The delegates also instructed the board of directors of the academy and its commission on hospitals to "seek more equitable representation for all branches of medicine on the Joint Commission on Accreditation of Hospitals."

In his address to the delegates, Dr. Richardson warned that in the face of "glowing" scientific achievements, "we may be seeing the last days of the practice of medicine as we have known it. The ranks of the family doctor have been thinned and in some areas decimated."

Noting that patients are not allowed to have their family physicians in some hospitals, Dr. Richardson acknowledged that "a few private practitioners of medicine still exist, but in the hospitals of some of our cities, a general practitioner cannot take a patient to a hospital, study his condition and diagnose and treat his case."

As a result of these changes, Dr. Richardson charged, "The patient falls into the hands of the specialist. He becomes a case. He is shunted about from specialist to specialist, and his medical expenses increase.

"The truth is that every patient needs a doctor who can watch the whole course of his medical care," Dr. Richardson continued. "The American Academy . . . will demand that every patient in every hospital in America be given the protection of having a qualified general practitioner as a safeguard in his case. We will demand this care be provided in every hospital. This, only, can protect that patient from the neglect of some other condition not in the field of the average specialist."

Dr. Richardson concluded by listing these "demands" of the academy:

"1. Open every hospital to the family doctor.

"2. Return every patient to the immediate care of his personal physician and whatever technical assistance his physician might feel is required.

"3. Require immediate revision of the rules of the various regulating agencies (the Joint Commission) to effect the above rules."

In another address to the academy, Dr. U. R. Bryner of Salt Lake City, Utah, academy president, deplored "sensational magazine articles about fee-splitting and unnecessary operations by dishonest surgeons" as tending to destroy public confidence in all doctors.

Much of the disagreement between groups in the medical profession is "useless and unwarranted," Dr. Bryner stated. Echoing the academy's battle cry, Dr. Bryner said much of the current strife "can be blamed on an oversupply of board-certified specialists—doctors who restrict their practice to a few specific ailments or to narrowly defined parts of the body." This theme was elaborated by Mac F. Cahal, executive secretary of the academy, who pointed out that "when the supply of specialists in a given field exceeds the demand, the specialists may seek to bar other doctors from treating cases of their type in hospitals. Thus, although a general practitioner may be

(*Continued on Page* 166)

Dr. Kenneth B. Babcock Succeeds Dr. Crosby as Head of Joint Commission

CHICAGO.—Dr. Kenneth B. Babcock, director of the Grace Hospital, Detroit, since 1947, has been named director of the Joint Commission on Accreditation of Hospitals, succeeding Dr. Edwin L. Crosby, the commission announced here last month. Dr. Babcock's appointment will become effective July 1.

A graduate of the University of Michigan, Dr. Babcock, who is 51 years old, was an intern and surgical resident at Grace Hospital, then an attending surgeon, before entering administration as assistant director of the hospital in 1941.

During the war, Dr. Babcock served in the army medical corps, reaching the rank of lieutenant-colonel. He returned to the hospital as medical director in December 1945 and served in that capacity for a year before becoming director.

A past president of the Michigan Hospital Association, Dr. Babcock is also a fellow of the American College of Surgeons, a fellow of the American College of Hospital Administrators, president of Michigan Hospital Service (Blue Cross), and a member of the American Hospital Association's council on prepayment plans and hospital reimbursement. He is also a member of the Blue Cross Commission.

Dr. Kenneth B. Babcock

Dr. Crosby, director of the Commission on Accreditation of Hospitals since it was organized in 1953, resigned recently to become executive director of the American Hospital Association. He will take office June 1.

The filing system is the answer to

Keeping Up With Accounts Payable

S. DAVID KAUFMAN
Certified Public Accountant, Brookline, Mass.

THE expansion program of Beth Israel Hospital, Boston, completed in 1950, increased facilities from 213 beds and no bassinets to 363 beds and 90 bassinets. In the office, we foresaw that the primary result of this program would be a tremendous increase in paper work. To discover and apply the best methods which would handle this all-time high volume of accounting work became an assignment with an underlined *must*.

One of our foremost problems would be accounts payable. Purchase orders, invoices, distribution cards and ledgers, all the records and work necessary for handling accounts payable would increase tremendously. We realized that we would either have to add more personnel—or we would have to develop a system which could efficiently handle the increased volume.

We decided to investigate the latter choice. And, as a result, we have developed an accounts payable system which keeps all work current—with ease, simplicity and at a low cost. Keynotes to the system are a new accounting machine and simplified filing.

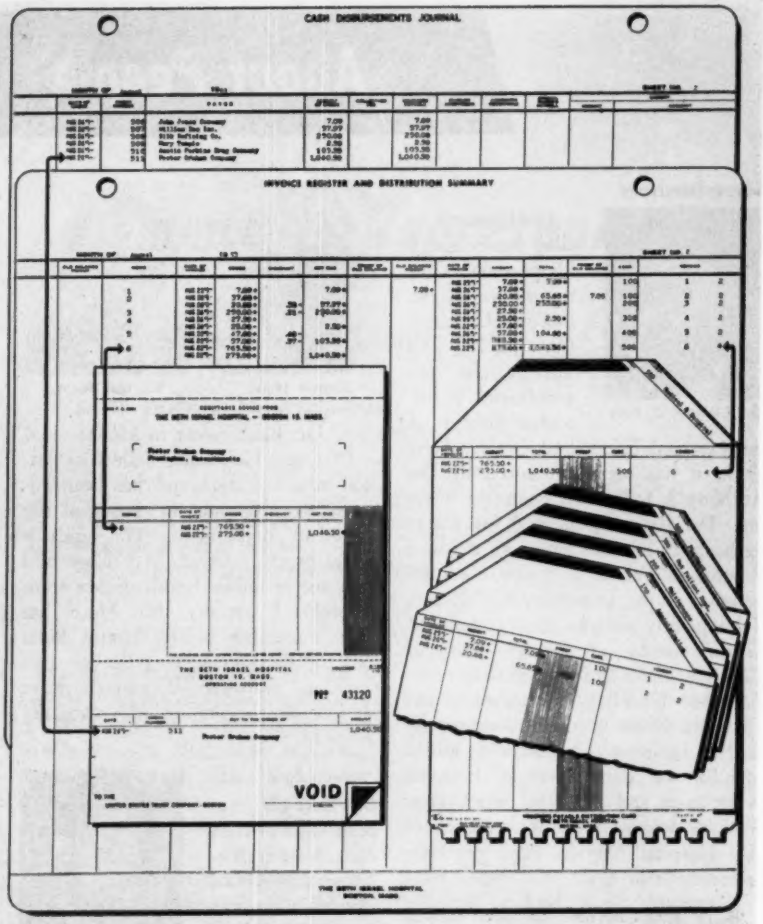
Despite expansion, one girl still handles all accounts payable work, and she does so on a current basis. Had we continued our pre-expansion methods it would have been impossible to keep work current.

When working out the new procedures, our first objective was to be able to start posting invoices for the current month even before closing out the previous month. We wished to avoid having the current month's work accumulate for 15 or 20 days while the invoices and statements for the preceding month were being checked, posted and closed out.

The second objective was to establish a simple method for handling and

Mr. Kaufman was formerly assistant director and controller of Beth Israel Hospital, Boston, a position he resigned to enter public accounting practice in Boston.

Mr. Kaufman, who developed the accounts payable system at Beth Israel Hospital, talking to Catherine E. Conway, operator of the accounting machine, which is one of the keynotes of the simplification of the accounting system.



At Beth Israel Hospital, the remittance advice, the distribution card, the invoice register and distribution summary are prepared in one operation. As the check is written (in duplicate), the cash disbursements journal is prepared automatically.

filing invoices during the posting process. We wished to avoid or eliminate much of the work involved in the usual method which requires one file for invoices that are not ready for posting, another file for invoices which are ready for posting, a third file for the invoices that have been posted, and still another file for the remittance advices themselves.

We feel we have accomplished these objectives very satisfactorily.

We first purchased two identical files, each of which could hold a month's work. The files provide for overlapping a series of cards by rows, so that the name of the vendor is visible on the upper right diagonal margin of the card. The cards show an expense distribution with the sums from the various invoices posted on them.

Each file also contains a set of jackets for filing the invoices and remittance advices. These jackets are also set up in rows, and the vendors' names are visible in the upper right diagonal margin. A duplicate set of vendors' jackets for collating the receiving slips with the invoices that are received in the daily mail is kept in the back of the file.

After the receiving slips are matched up with the invoices and checked for posting, they are put into the first set of jackets in front of the remittance advice. This indicates that they are ready to be posted. The posted invoices are placed behind the remittance advice. At the end of the month, the posted invoices are stapled to the copy of the remittance advice and are filed by the vendors' names.

By using the jackets we have eliminated the necessity for separate files in which to keep the invoices and remittance advices during the various stages of work.

We handle all of our accounts payable work—from posting invoices and check writing to distributing expenses to their account—on one accounting machine.

Remittance advices and checks are prepared in the same operation, with the voucher register provided as a by-product. Accumulated totals are printed automatically at the end of a run or whenever desired. The voucher copy of each check is attached to the invoices and combined purchase order and receiving slip. Thus each copy of the check has attached to it all the evidence necessary to support payment to the vendor. Through this method, we have eliminated the possibility of duplicate payments being made to a vendor.

Distribution ledgers are kept up to date so that we always have on hand an analysis of expenses. Here again all totals are provided automatically.

By assigning code numbers to vendors we gained additional speed in the operation. This coding system eliminated the necessity of typing a vendor's name for each posting.

The entire system is so simple that after an hour or two of training almost anyone can understand it and learn to handle the postings.

About People

Administrators


Dr. Clement C. Clay

Dr. Clement C. Clay has resigned his position as administrator of the Hospital Center at Orange, N.J., to accept the appointment of associate director of the Hospital Council of Greater New York, it has been announced by **Dr. Anthony J. J. Rourke,** executive director. Dr. Clay commenced his career in hospital administration as a Julius Rosenwald Fellow in hospital administration at the University of Chicago. Subsequently he was medical assistant to the director of the University of Chicago Clinics and then director of St. Barnabas Hospital, Minneapolis. Dr. Clay is a fellow of the American College of Hospital Administrators and a member of the American Hospital Association and the New Jersey Hospital Association. He is a trustee of the Hospital Service Plan of New Jersey.

R. Arthur Carvolth has been named administrator of the new St. Luke Hospital, Fort Thomas, Ky. Mr. Carvolth was formerly director of Portsmouth General Hospital, Portsmouth, Ohio. His successor at Portsmouth is **Joseph S. Hew,** formerly administrator at Highland Community Hospital, Hillsboro, Ohio. Mr. Carvolth holds the degree of master of business administration from Columbia University.

Harold K. Wright, superintendent of Methodist Hospital, Sioux City, Iowa, since 1941, has joined the staff of the Board of Hospitals and Homes of the Methodist Church, with headquarters in Chicago, as associate in institutional services. He assumed his new duties on May 1. Mr. Wright has been succeeded at Methodist Hospital by **James L. Dack,** formerly assistant director of the University of Maryland Hospital, Baltimore. Mr. Wright is a past president of both the Iowa Hospital Association and the Upper Midwest Hospital Conference.


Andrew Mezei


Dr. Max Fuchs

Andrew Mezei and **Dr. Max Fuchs** have been appointed assistant directors of Mount Sinai Hospital, New York City. Dr. Fuchs went to Mount Sinai in 1951 as a Goldwater Fellow in hospital administration and has been administrative assistant in charge of the outpatient department. He holds a dental degree from Tufts College and a master of public health degree from Columbia University. Mr. Mezei has been a member of the Mount Sinai staff for 27 years, serving the last two years as manager of administrative services for the private and maternity pavilions.


R. W. Bachmeyer

Robert W. Bachmeyer has been appointed director of St. Barnabas Hospital, Minneapolis, succeeding **Dr. Karl Klicka.** Mr. Bachmeyer has been director of Aultman Hospital, Canton, Ohio, since 1947. A graduate of the program in hospital administration at the University of Chicago, Mr. Bachmeyer was assistant director of Children's Hospital, Boston, before moving to Ohio. He was a medical administrative officer in the army during the war. At the time his appointment to the Minneapolis position was announced, Mr. Bachmeyer had just taken office as president of the Ohio Hospital Association.


J. Walsh Stull

J. Walsh Stull, administrator of Charleston Memorial Hospital, Charleston, W. Va., since 1949, is now administrator of Riverside Community Hospital, Riverside, Calif., succeeding **Harry D. Keller.** Before moving to Charleston, Mr. Stull had been resident administrator of Bogalusa Medical Center for Gaylord Container Corp., at Bogalusa, La., and from 1944 to 1947 had been administrative assistant and assistant to the director at Wesley Memorial Hospital, Chicago. Earlier, Mr. Stull was hospital business manager for the War Relocation Authority at Rivers, Ariz., and business manager for Ryder Memorial Hospital, Humacao, Puerto Rico. Mr. Stull received his master's degree in hospital administration from Northwestern University.

Edward E. James has resigned as director of the North Shore Hospital, Manhasset, Long Island, N.Y., a post he has held since 1951. Mr. James will remain at the hospital until his successor is named. He has not announced his plans for the future.


Richard H. Ward

Richard H. Ward has been appointed administrative assistant for outpatient services, Roosevelt Hospital, New York City. A graduate of the Columbia University course in hospital administration, Mr. Ward has a bachelor's degree in business administration from New York University and is also a graduate nurse. He served a two-year administrative residency at Presbyterian Hospital, New York City, and remained as administrative assistant until his present appointment at Roosevelt. Mr. Ward replaces **Eleanor Peterson,** who resigned April 1 to become assistant director of Wyckoff Heights Hospital, Brooklyn, N.Y.

Dr. Joseph P. Nothum has been appointed administrator of Doctors Hospital, Milwaukee. Dr. Nothum joined the hospital staff three years ago as an administrative assistant and has been serving as acting administrator for the last year.

Dr. J. E. Moody, medical director of Leland Sanatorium, Ypsilanti, Mich., has been named medical director and superintendent of Boehne Hospital, Evansville, Ind., succeeding **Dr. Paul D. Crimm.** Dr. Crimm is retiring after 25 years as head of Boehne Hospital.

(*Continued on Page* 168)

Conducted by Raymond P. Sloan

Community Representatives

interpret hospital to public and public to hospital

JOHN P. AMSDEN
President, Board of Trustees
Mary Hitchcock Memorial Hospital, Hanover, N.H.

THE Mary Hitchcock Memorial Hospital at Hanover, N. H., serves an area in the upper Connecticut Valley in New Hampshire and Vermont in which there are about 30 towns, varying in population from 1000 to about 15,000. Some of these towns have no hospital of their own; others have excellent small hospitals. For these latter the Mary Hitchcock serves as a referral hospital, or second line of defense. About 85 per cent of our patients come from outside the town in which the hospital is located.

We have felt, as other hospitals must have, that our relations with the communities we serve frequently suffer from misunderstandings or lack of accurate information. This situation could be avoided to a large extent if some means could be found to make authentic information readily accessible to the residents of these communities.

It is also distressing to hear at fourth hand of criticisms of our service weeks after the incident occurred. These complaints can be handled much more effectively if we can learn about them directly while the occasion is fresh in the minds of all concerned. There are some who prefer to nurse a grievance rather than reporting it so that it may be corrected. For these we would like to make the process of letting us know about it as easy as possible.

It appeared that the need was for a two-way street which would provide for the ready flow of information from the hospital to the communities and for the equally ready flow of suggestions or criticisms in the opposite direction. There is, for some persons, a certain amount of embarrassment or inertia to be overcome in approaching hospital authorities in another town. This obstacle is not such a serious one when the approach can be made to a friend in the person's own community.

As we so frequently do in case of need, we turned to the ladies for help. A letter was sent to one or more women in each community explaining our problem and asking their assistance. The recipients of these letters were known to be interested in the hospital and to be well known and highly regarded in their communities. These women were invited to be the guests of the hospital at luncheon in the hospital cafeteria and to meet the administrator, the chief of staff, and the president of the trustees. About 30 acceptances were received.

At a meeting following the luncheon the representatives of the administration, staff and trustees each discussed briefly their rôle in the operation of the hospital, their concern for good relations with the communities served, and their appreciation of the willingness of the ladies present to serve as community representatives of the hospital.

In return for their assistance the hospital pledged three things: (1) that the community representatives would not be called upon to solicit money for the hospital (this immediately established good public relations with the group); (2) that the hospital would furnish them with as complete information as was possible con-

Mr. Amsden meets with a group of community representatives, to discuss community relations.

cerning all phases of hospital operation; (3) that all suggestions or complaints submitted through them would receive prompt attention.

The program, as worked out with the community representatives, calls for a meeting every other month. These meetings start with a luncheon at the hospital, following which some phase of hospital operation is discussed by the person responsible for it. To date these discussions have included a consideration of the relation of the voluntary community and regional hospitals to the areas they serve; the relation of the medical staff to the hospital, the patient, and the referring doctor; and the nursing service and nursing education work of the hospital. Future topics will include housekeeping, dietary, maintenance, social service, medical records, and so on. Wherever possible an inspection of the facilities discussed will follow the meeting. At the conclusion of each meeting, time is devoted to answering questions and noting suggestions or criticisms for prompt attention. These meetings are always attended by the administrator and the president of the trustees.

The effectiveness of the program is indicated in the following examples of typical problems that have arisen and have been handled successfully through the community representatives organization:

1. In its early days we got a report from one of the members that someone in her community was criticizing the hospital because of having "needlessly" spent money for toilets in every room in our new building. They were not needed, in her opinion, because people when they were sick in the hospital could not use the bathrooms anyway. We sent word back through the community representative, which apparently satisfied this person, at least on the surface, to the effect that early ambulation and other factors made it quite essential that we have toilets in every room. Not too long afterward, this person herself was hospitalized for a rather minor ailment for which she was ambulatory almost all the time she was here. She made herself known and indicated her initial thought, confessing at the same time that she understood perfectly why the investment in the bathroom facilities had been made and admitted that unquestionably they were a distinct and necessary asset.

2. We knew we had a parking problem, but as a country town hospital didn't think it was too terribly serious. One of our community representatives, who had been receiving physical medicine treatments as an outpatient, commented bitterly at one of the meetings that whenever she came in for a physical therapy treatment, which was on the basis of three times a week for a matter of some weeks, she found it necessary to plan on getting to the hospital at least 15 to 20 minutes early to find a parking space. This brought nods of agreement from the rest of the members for one reason or another, and was one of the factors which spurred us on, with the aid of the trustees, to invest a considerable sum in what are now adequate, off-the-street parking lots.

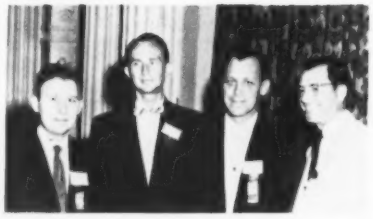
Following the initial meeting, all the newspapers in the area were sent releases giving the objectives of the program and the name and home communities of the representatives. The interest and response by the representatives have been most encouraging. The program is a long-range one, and we feel that it will accomplish something in the way of community relations that might not be done so successfully in any other way.

Speakers at Southeastern Meeting Stress "Human Engineering" Problems

ATLANTA, GA.—Ritz E. Heerman, president of the American Hospital Association, was the opening speaker for the Southeastern Hospital Conference here. Mr. Heerman praised the present administration's reinsurance bill up for discussion in Congress, saying that, if enacted, it would protect the low wage earner in case of catastrophic illness. He also urged support of the Hill-Burton program. "For hospitals to be of maximum service," Mr. Heerman said, "people should be educated as to the value of hospital service and urged to take part in prepayment insurance plans." Charles W. Holmes of Memphis, president of the Southeastern Hospital Conference, said that one of the big problems of hospitals today is that many patients don't know the limitations of their hospitalization insurance policies. They are upset when they learn that their policies won't pay the full cost of their rooms or all extra service bills.

L. D. Daily, director of Associated Management Consultants of Denver, discussed administrative practices and asked whether the same energies and intelligence which have sparked the industrial, agricultural and economic development in the South have been made available to improve hospital administration. Hospitals, he said, have a built-in advantage over other organizations, and that is a sincere desire on the part of employes to help and serve sick people. "This motivation," he continued, "must be channeled into more effective action on behalf of patients."

One of the interesting and well attended events of the convention was the "buzz session" for small hospitals



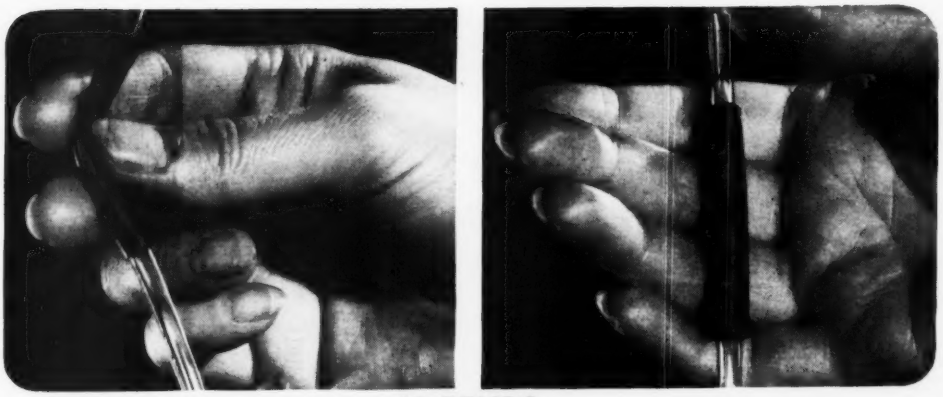
Southeastern officers; l. to r.: Pat Groner, secretary-treasurer; D. O. McCluskey Jr., president-elect; John Gill, president, and John F. Wymer, vice president of the association.

conducted by Maurice Norby of the American Hospital Association on Wednesday afternoon. Medical staff rules, medical records and methods for achieving accreditation of the hospital were discussed.

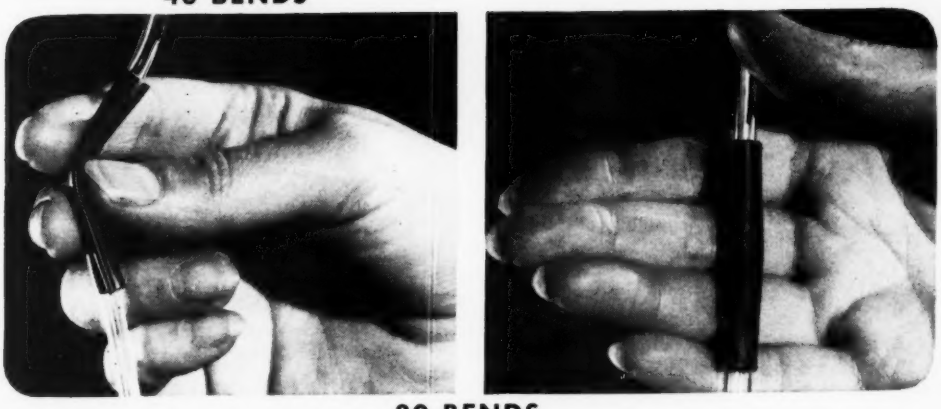
The sectional meeting for large hospitals heard Robert Bertrand, chief engineering officer of the Veterans Administration Hospital in Augusta, Ga., emphasize the need for a registered professional engineer with executive and supervisory ability to head

(*Continued on Page* 164)

Left: Allen V. R. Beck, president, American Society of Hospital Pharmacists; right: Johnnie Crotwell, retiring head of Southeastern pharmacists.



40 BENDS



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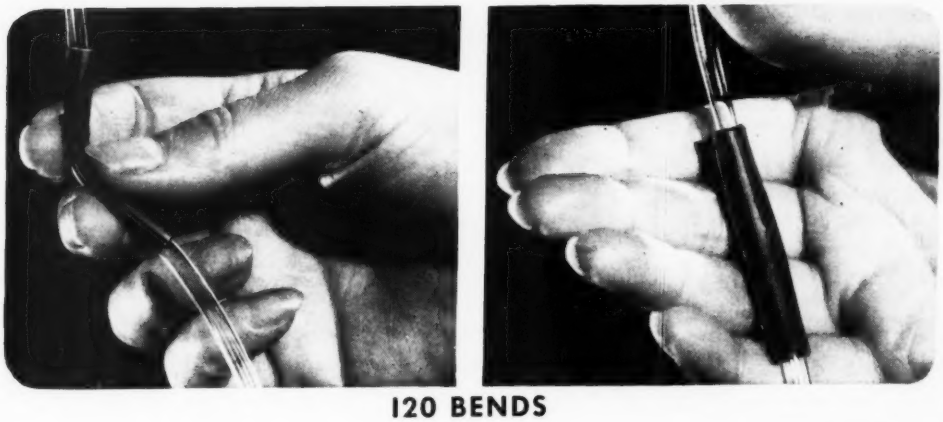

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Conducted by Robert F. Brown, M.D.

For the benefit of hospitals that are planning to install a blood bank, here are some useful

Facts on Hospital Blood Bank Services

DAVID F. BURGOON
Laboratory Consultant
Division of Medical and Hospital Resources
Public Health Service, Washington, D.C.

AN ESTIMATED five million pints of blood were used to save American lives in 1951. More of this blood was procured and issued by blood banks in hospitals than by any non-hospital agency. The necessity of carefully programming and planning these services is evident from the magnitude and importance of the blood bank in the hospital.

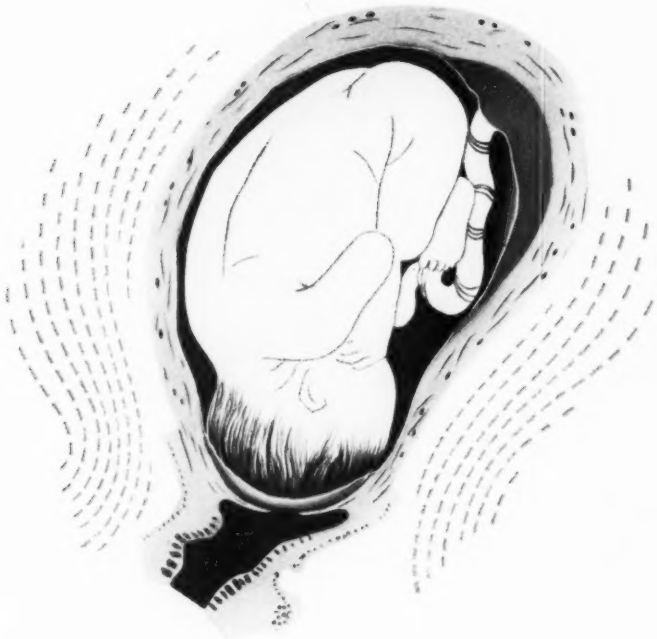
One of the best sources of information on blood banks is the American Medical Association's report of a study it conducted in 1950.* Besides being a directory of hospital blood banks by states, it includes information on the number of 500 cc. units of blood issued, the sources of this blood, stocks of blood, and bleeding capacity. Such material would be more useful to hospitals planning blood banks if the facts could be presented in greater tabular detail. An analysis of the data was made, according to size, type and control of the hospitals providing blood bank service. The results are presented in this paper.

Although 1445 blood banks in hospitals were listed in the American Medical Association's report, many had to be excluded before analysis was attempted. The reasons for exclusion were: location outside continental United States; failure to answer ques-

*Dickinson, Frank G., and Walker, Everett L.: Second Survey of Blood Banks, a Report to the Committee on Blood Banks. Bulletin 83, American Medical Association, Bureau of Medical Economics Research, 1951.

Table 1—Number of Units (500 cc.) of Blood Issued per Year, General Hospitals (Nonprofit)

Hospital Bed Size	No. of Blood Banks	No. of Hosp. Beds	Units (500 cc.) Blood Issued	Av. No. Units Issued per Blood Bank	Av. No. Units Issued per Hosp. Bed
Under 50	56	1,973	9,361	167	4.7
50-99	190	13,894	73,355	386	5.2
100-249	503	84,716	484,140	962	5.7
250 and over	246	87,461	668,403	2,717	7.6
TOTAL	995	188,044	1,235,259	1,241	6.5
General Hospitals (Government-Nonfederal)					
Under 50	16	559	2,116	132	3.7
50-99	39	2,580	14,905	382	5.7
100-249	55	8,964	62,004	1,127	6.9
250 and over	70	57,003	404,798	5,783	7.1
TOTAL	180	69,106	483,823	2,688	7.0
General Hospitals (Government-Federal)					
Under 50	2	100	82	41	0.8
50-99	0	0	0	0	0
100-249	2	436	818	409	1.8
250 and over	65	46,426	145,423	2,237	3.1
TOTAL	69	46,962	146,323	2,121	3.1
General Hospitals (Proprietary)					
Under 50	21	672	4,722	225	7.0
50-99	19	1,199	10,682	562	8.9
100-249	23	3,611	23,155	1,007	6.4
TOTAL	63	5,482	38,559	612	7.0
Special Hospitals					
Under 50	1	30	67	67	2.2
50-99	9	685	7,317	813	10.6
100-249	15	2,656	9,503	633	3.6
250 and over	24	19,204	25,431	1,060	1.3
TOTAL	49	22,575	42,318	863	1.9
ALL BLOOD BANKS	1,356	332,169	1,946,282	1,434	5.8



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*Kaufman, R. H.; Mendelowitz, S. M., & Ratzan, W. J.: *Am. J. Obst. & Gynec.* 65:269, 1953.

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tionnaire; information not available as to type and size of hospital; service provided to more than one type of patient, *e.g.* general-tuberculosis. Thus the available data on the amount of blood issued and sources of blood cover 1356 hospitals; average stock information was supplied for 1330 hospital blood banks, and normal bleeding capacity was given for 1282.

For purposes of this study, hospitals were divided into two types, general and special. The special hospitals include tuberculosis, cancer, children's, maternity, mental, orthopedic, chronic disease, gynecology and industrial. Because of the small number (only 49, of which 20 were tuberculosis hospitals) these special hospitals were considered as a group and were not classified by type of control.

Volume. The amount of blood issued per year by hospital blood banks, according to type, size and control of hospital is shown in Table 1. The largest amount, 1,235,259 units (63 per cent of the total) was issued in the general, nonprofit hospitals. However, the group issuing the largest number of units per blood bank is the general, government-nonfederal. The fact that most state university medical centers are in this category is probably a reason for this. One would expect these institutions to perform the more complicated surgery and treat the more complex medical cases and, hence, use more blood. In the general, government-federal group, a factor influencing the high rate of units of blood issued per blood bank, despite the relatively low rate per bed (3.1), is that 94 per cent of these blood banks are in the size group of 250 or more beds. The low per bed rate is due to the weighting given the group by the Veterans Administration hospitals, which comprise more than 50 per cent of the total.

Data on the average number of units of blood issued per bed indicate only slight differences in the groups comprising the general-nonprofit and government-nonfederal and the proprietary hospitals, which were 6.5, 7.0, and 7.0 units respectively. Special hospitals were low in this regard, averaging only 1.9 units per bed. This is understandable since 40 per cent of this group are tuberculosis hospitals where the need for blood is not as great. These variations emphasize the importance of knowing the type of patient and hospital for which blood banks are being planned.

Source. One of the most difficult problems in the operation of blood banks is maintaining an adequate supply of blood. Table 2 shows that the hospital blood bank relies heavily on blood directly from donors. Three-fourths of it is furnished from this

(*Continued on Page 98*)

Table 2—Sources of Blood, General Hospitals (Nonprofit)

Hospital Bed Size	No. of Blood Banks	Units (500 cc.) Blood Issued	Sources			
			Donors	Other Hosp. Banks	Non-Hosp. Banks	Red Cross Centers
Under 50	56	9,361	28%	2%	10%	60%
50-99	190	73,355	66	3	3	28
100-249	503	484,140	72	6	8	14
250 and over	246	668,403	80	4	5	11
TOTAL	995	1,235,259	76%	5%	6%	13%
General Hospitals (Government-Nonfederal)						
Under 50	16	2,116	42%	2%	<1%	56%
50-99	39	14,905	62	3	2	33
100-249	55	62,004	83	1	4	12
250 and over	70	404,798	87	1	2	10
TOTAL	180	483,823	86%	1%	2%	11%
General Hospitals (Government-Federal)						
Under 50	2	82	10%	61%	29%	0
50-99	0	0	0	0	0	0
100-249	2	818	14	2	0	84
250 and over	65	145,423	46	16	22	16
TOTAL	69	146,323	46%	16%	21%	17%
General Hospitals (Proprietary)						
Under 50	21	4,722	61%	1%	8%	30%
50-99	19	10,682	63	1	3	33
100-249	23	23,155	55	28	7	10
TOTAL	63	38,559	58%	17%	6%	19%
Special Hospitals						
Under 50	1	67	0	0	0	100%
50-99	9	7,317	87	<1	<1	13
100-249	15	9,503	58	2	13	27
250 and over	24	25,431	36	15	27	22
TOTAL	49	42,318	50%	9%	19%	22%
ALL BLOOD BANKS	1,356	1,946,282	75%	5%	7%	13%

Table 3—Average Number of Units of Blood in Stock General Hospitals (Nonprofit)

Hospital Bed Size	No. of Blood Banks	Av. No. of Units (500 cc.) Issued per Blood Bank	Total Av. Stock	Av. Stock per Blood Bank	Av. Stock per Hosp. Bed
Under 50	51	165	370	7	0.20
50-99	186	387	2,711	14	0.19
100-249	499	967	13,603	27	0.16
250 and over	243	2,721	14,942	61	0.17
TOTAL	979	1,250	31,626	32	0.17
Not reporting	16				

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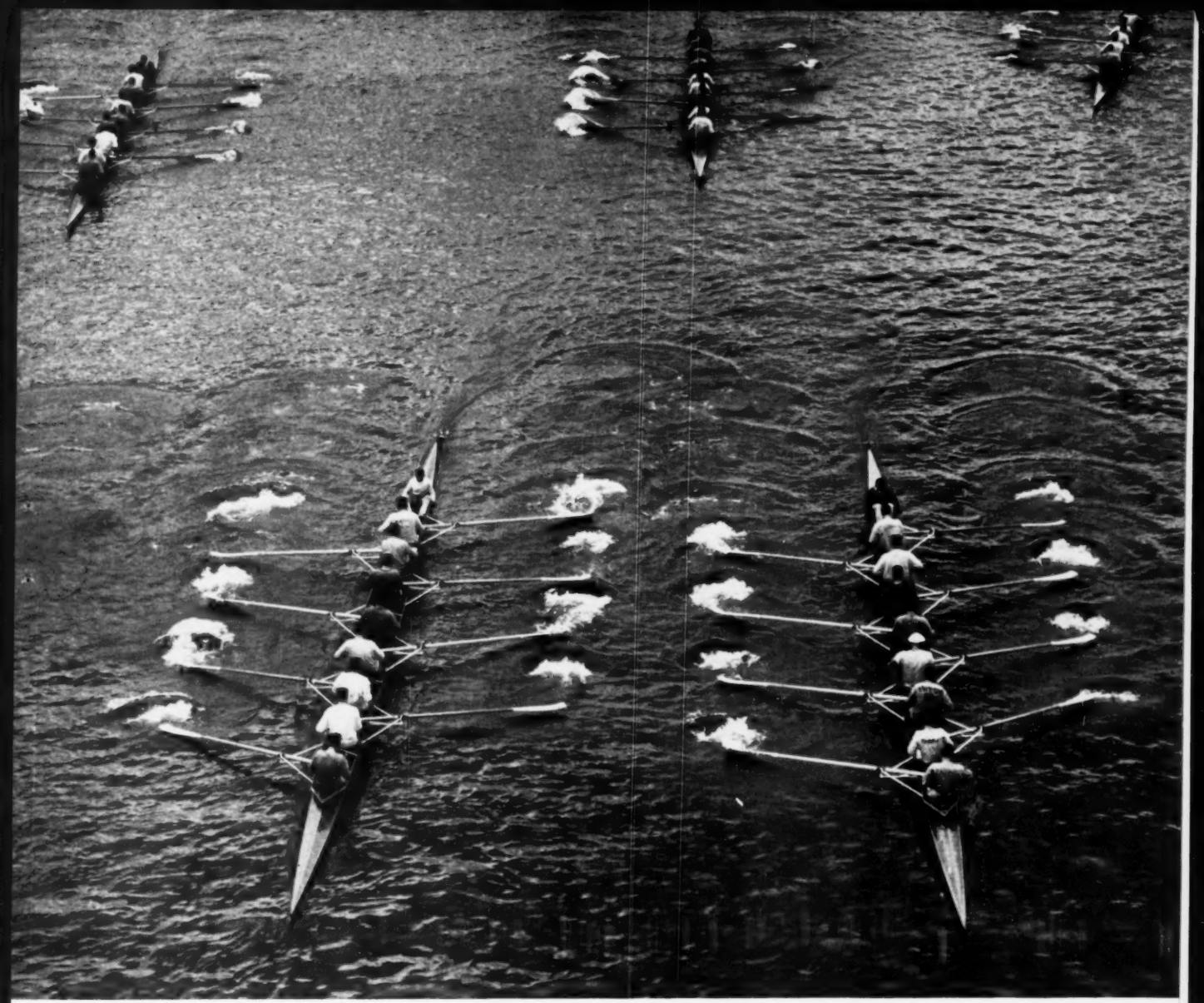

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Table 3—Average Number of Units of Blood in Stock
General Hospitals (Nonprofit) (Cont.)

Hospital Bed Size	No. of Blood Banks	Av. No. of Units (500 cc.) Issued per Blood Bank	Total Av. Stock	Av. Stock per Blood Bank	Av. Stock per Hosp. Bed
General Hospitals (Government-Nonfederal)					
Under 50	15	139	96	6	0.18
50-99	39	382	530	13	0.20
100-249	54	1,138	1,411	26	0.16
250 and over	70	5,783	7,702	110	0.13
TOTAL	178	2,715	9,139	55	0.14
Not reporting	2				
General Hospitals (Government-Federal)					
Under 50	2	41	9	4	0.09
100-249	2	409	23	11	0.05
250 and over	63	2,271	3,383	54	0.08
TOTAL	67	2,149	3,415	51	0.08
Not reporting	2				
General Hospitals (Proprietary)					
Under 50	19	228	200	10	0.32
50-99	17	610	280	16	0.25
100-249	22	954	443	20	0.13
TOTAL	58	616	923	16	0.18
Not reporting	5				
Special Hospitals					
Under 50	1	67	2	2	0.06
50-99	9	813	107	12	0.16
100-249	14	645	318	23	0.13
250 and over	24	1,060	498	21	0.03
TOTAL	48	872	925	19	0.04
Not reporting	1				
ALL BLOOD BANKS.	1,330*	1,450	46,628	35	0.14
*Total Not Reporting	26				

Table 4—Average Normal Bleeding Capacity, General Hospital (Nonprofit)

Hospital Bed Size	No. of Blood Banks	Total Bleeding Capacity	Av. Bleeding Capacity
Under 50	46	120	2.6
50-99	179	509	2.8
100-249	478	1,200	2.5
250 and over	238	729	3.0
TOTAL	941	2,558	2.7
Not reporting	54		
General Hospitals (Government-Nonfederal)			
Under 50	14	29	2.0
50-99	35	73	2.0
100-249	55	148	2.7
250 and over	70	266	3.8
TOTAL	174	516	2.9
Not reporting	6		
General Hospitals (Government-Federal)			
Under 50	2	2	1.0
50-99	0	0	0
100-249	2	9	4.5
250 and over	64	204	3.1
TOTAL	68	215	3.1
Not reporting	1		
General Hospitals (Proprietary)			
Under 50	19	42	2.2
50-99	17	69	4.0
100-249	21	32	1.5
TOTAL	57	143	2.5
Not reporting	6		

(Continued on Page 98)

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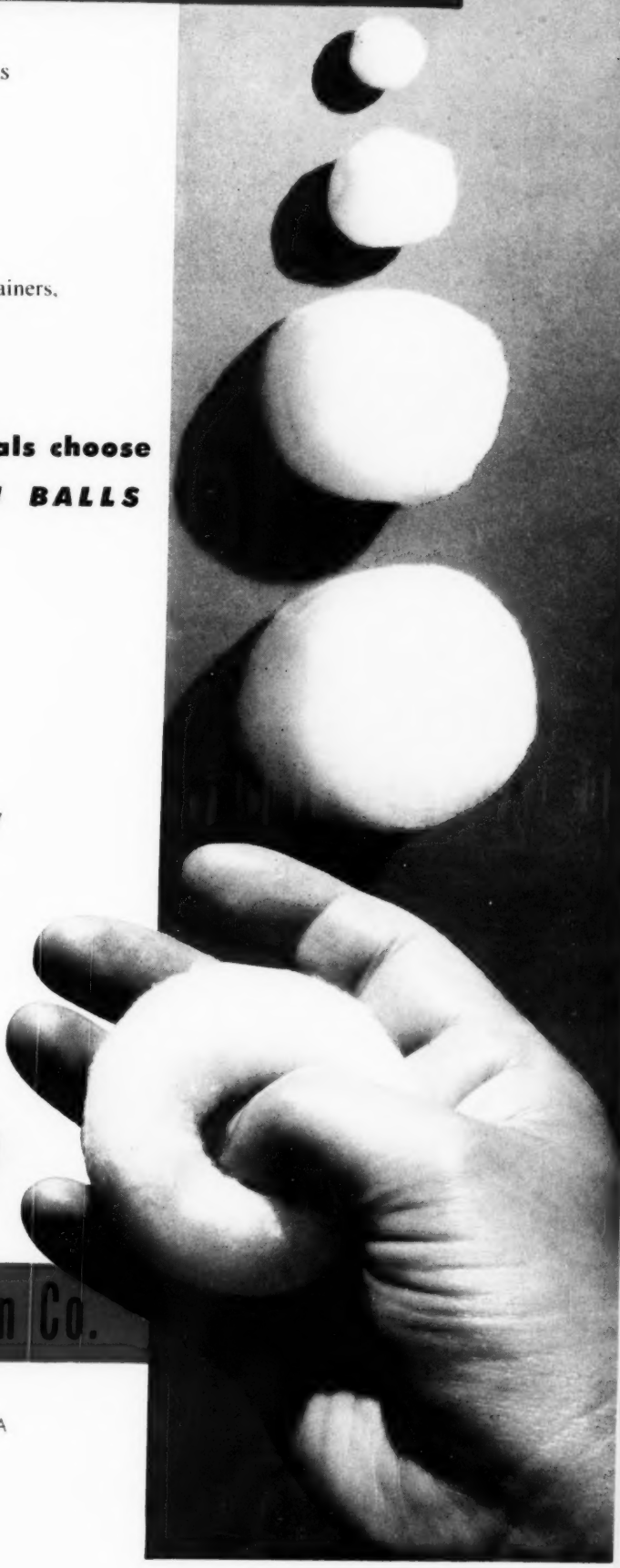

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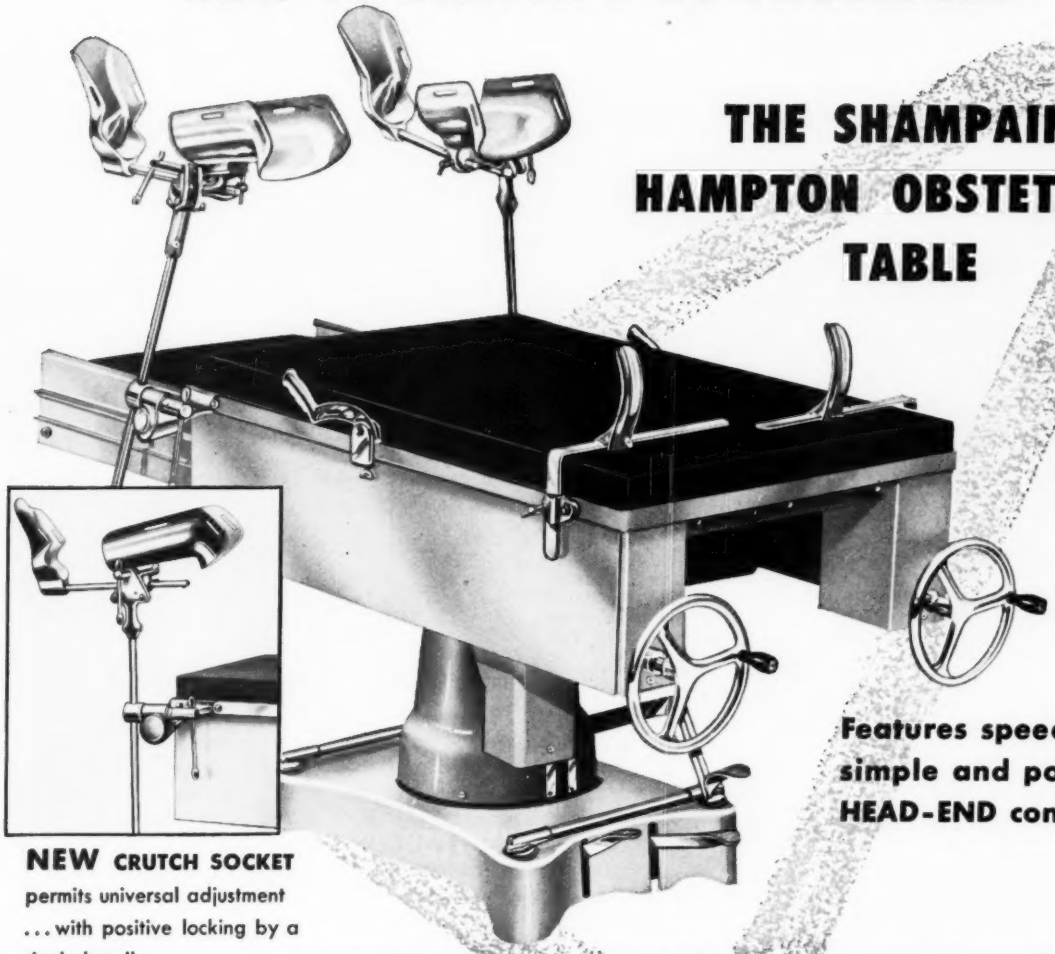

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Table 4—Average Normal Bleeding Capacity, General Hospitals (Nonprofit) (Cont.)

Hospital Bed Size	No. of Blood Banks	Total Bleeding Capacity	Av. Bleeding Capacity
Special Hospitals			
Under 50	1	1	1.0
50-99	8	21	2.6
100-249	14	22	1.5
250 and over	19	65	3.4
TOTAL	42	109	2.5
Not reporting	7		
ALL BLOOD BANKS	1,282*	3,541	2.7
*Total not reporting	74		

Table 5—Distribution of Blood Banks by Size in General Hospitals (Nonprofit)

Blood Banks Size: Units of Blood Issued		Bed Size				No. of Blood Banks	Per Cent
		Under 50	50-99	100-249	250 and Over		
Per Year	Per Week						
000-499	0-10	54	141	104	0	299	30
500-999	10-19	2	44	216	15	277	28
1000-1499	19-29		4	106	41	151	15
1500-1999	29-38		0	45	46	91	9
2000-2999	38-58		1	27	74	102	10
3000-3999	58-77			3	34	37	4
4000-4999	77-96			2	15	17	2
5000 and over	96				21	21	2
No. of Blood Banks		56	190	503	246	995	100

(*Continued From Page 94*)

source. The next largest source is the Red Cross centers, which supply 13 per cent. The fact that 75 per cent of the blood issued by hospital blood banks is directly from donors demonstrates the necessity of the hospital's obtaining community support in meeting the ever increasing demands for blood.

It is interesting to note that blood banks in hospitals of fewer than 50 beds in the nonprofit general and nonfederal government groups depend largely on the Red Cross centers for blood, but the dependence on this source decreases as the volume of blood issued increases. This would seem to indicate that most small hospitals will run into difficulty in operating their blood banks if their only source of supply is the donor. Small hospitals therefore should make arrangements for outside help in maintaining their blood banks, such as the Red Cross, other hospitals or nonhospital banks.

Stock. The amount of stock provided in hospital blood banks is based on the demand. Table 3 shows that the average quantity of units in stock is directly related to the number of units issued. The average amount of stock increases with the size of the hospital, regardless of the hospital's control or type. However, when the average stock is based on units per hospital bed, less variation is found, which indicates that units per bed would be a better guide for estimating the approximate stock to be maintained.

Bleeding Capacity. Table 4 indicates that hospitals, regardless of type or size, differ little in provisions made for bleeding donors. The average in all hospitals approximates facilities for three donors to be bled simultaneously.

Planning. Programming is essential in planning the facility of a blood bank service in the hospital. Table 5 provides some guide lines for the hospital blood bank program by showing the volume of work to be performed in blood banks in hospitals of various sizes. When using this table, remember that experience indicates an increase in volume once the service is established and that provision for expansion should be made in any planning. Data are presented for the nonprofit general group only, since more than 70 per cent of the hospitals in the United States are in this category and 73 per cent of the blood banks, issuing 63 per cent of the blood, are in this classification.

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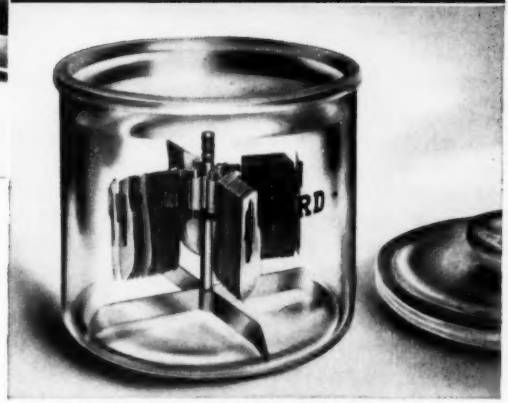

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Prepared by the Committee on Pharmacy and Therapeutics
University of Illinois College of Medicine, Chicago 12

LOCAL ANESTHETICS

LOCALIZED loss of sensation or local anesthesia may be produced by both physical and chemical means. Chilling or freezing of the body tissues with ice or with ethyl chloride spray are familiar examples of anesthesia by physical means. Ice anesthesia is applicable only to extremities and its production is difficult and time consuming, while freezing with ethyl chloride spray is superficial, transient, interferes with operative procedures, and is frequently followed by pain secondary to the freezing of the tissues. These procedures are useful in selected cases only, in contrast to the widespread usefulness of local anesthesia produced by chemical agents, the local anesthetics.

Local anesthesia may be produced by any agent which damages or destroys nerve tissue, such as phenol, quinine or alcohol. These agents produce irreversible or long lasting anethesia associated with the destruction of nerves and their surrounding tissues. This type of anesthesia is desirable only rarely. Those agents which produce reversible anesthesia without damaging body tissues have come to be known as local anesthetics.

HISTORICAL

Cocaine, an alkaloid extracted from a South American plant, was the first local anesthetic. Although noted earlier, its remarkable local anesthetic properties were rediscovered by Karl Köller and Sigmund Freud. It was subsequently introduced into medicine by Köller in 1884 as a topical anesthetic for ophthalmic surgery. The use of cocaine spread rapidly, and by 1885 Halstead, an American surgeon, reported on 100 operations performed under nerve block anesthesia with cocaine. Cocaine proved to be quite toxic, however, and frequent deaths were reported following the injection of very small amounts of the drug. Furthermore, the central stimulating effects of the drug, for which the coca leaf had been chewed for centuries by the South American Indians, were leading to addiction in susceptible individuals.

In 1905, following the preparation of an extensive series of compounds based on the partial structure of cocaine, Einhorn announced the synthesis of procaine (novocaine) which was much less toxic than cocaine and did not have the central effects which lead to addiction. Procaine was rapidly adopted and is today the safest and most widely used local anesthetic. Procaine is, however, somewhat toxic; it has a short duration of action, and is ineffective topically. For these reasons the search for better local anesthetics has continued. Since the introduction of procaine many thousands of local anesthetics have been synthesized and tested. Some have been more potent and some have been less toxic than procaine, but only a few have advantages sufficient to make their retention in medicine worth while.

IDEAL LOCAL ANESTHETIC

The ideal local anesthetic should have the following properties:

1. It should be easily water soluble and stable in solution.
2. It should be nonirritating upon local application or injection.
3. It should produce anesthesia without damage to nerve structure.
4. It should have a low systemic toxicity, since it is absorbed from the injection site.
5. It should have a rapid onset of action and a duration of anesthesia sufficiently long to allow ample time for surgical procedures.
6. It should penetrate mucous membranes when applied locally.
7. It should have no after hyperesthesia, *i.e.* temperature felt as pain or touch felt as soreness.
8. It should have a vasoconstrictor effect or be compatible with epinephrine.

Neither procaine nor any of its substitutes fulfills all of these qualifications.

To determine potency and duration of anesthesia, these drugs are tested on the mucous membrane of the human tongue, on the frog sciatic nerve, on the cornea of the rabbit's eye and by intradermal wheals formed in the skin of the guinea pig and man. In addition to the effective dose the lethal dose of the drug is determined in experimental animals. From these data an expression is derived which is known as the therapeutic ratio or index. In general, it is said that the larger the index the safer the drug. For clinical comparison of effectiveness of new local anesthetics, procaine has been used as the reference drug.

MODE OF ACTION

The mode of action of local anesthetics is not known. All of them produce block of conduction in peripheral nerve without changing the resting potential of the nerve; that is they prevent propagated depolarization of the nerve membrane. Different types of nerve fibers are anesthetized at varying rates by local anesthetics. Vasomotor function and the sensations of pain, cold, warmth and touch disappear in that order following applications of local anesthetics to nerve trunks. The last functions to disappear are those subserved by the motor nerves and the nerves of proprioception. This order of anesthesia has been shown to be correlated with the size of

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Procaine HCl	1000	0.5 to 1.0%	10%	Infiltration and spinal traumatized urethra	200	5%	1−
Piperocaine (Metycaine HCl)	750	0.5 to 1.0%	2% 4%	Eye Larynx(?), nose, throat, urethra(?)	150	5%	1+
Cocaine HCl	100	Never!	0.5-1.0% 5%	Eye(?) Nose, throat, larynx(?)	Never!	—	—
Butacaine (Butyn Sulfate)	75	Never! too toxic to spray	2%	Eye	Never!	—	—
Tetracaine HCl (Pontocaine)	50	1:100 0.1% (pro- duces edema)	0.5% 1.0%	Eye Larynx(?), nose, throat Spinal and nerve block	15-20	0.5%	1.5-2
Dibucaine (Nupercaine HCl)	25	0.05% 1:2000	0.1% 0.1-1.0%	Eye Larynx, hemorrhoids, pruritis	6-12	0.1%	3-4
Lidocaine (Xylocaine HCl)	750	0.5 to 1.0%	1.0%	Spinal and nerve block infiltration...	100	2%	2-3

nerve fibers, the smaller fibers being the most sensitive to the anesthetic agent.

Local anesthetics can also be shown to block many of the peripheral effects of acetylcholine. For this reason and the fact that analogies can be drawn between the structure of acetylcholine and many of the local anesthetics, it has been postulated that these drugs act by blocking the action of acetylcholine. However, the rôle of acetylcholine in nerve conduction is not clear and acceptance of this postulate is dependent upon the proof of the necessity of acetylcholine for conduction in peripheral nerves. Local anesthetics also antagonize many of the effects of histamine and many of the antihistaminics are effective local anesthetics.

Although injected as their water soluble hydrochlorides, it can be shown that the local anesthetics penetrate and affect nerves as free bases, and as free bases the local anesthetics obey in general the Meyer-Overton law of lipid solubility, the more potent drugs being more oil soluble.

PROPERTIES OF LOCAL ANESTHETICS

All local anesthetics are central nervous system poisons and in high doses produce convulsions, respiratory arrest and death. In rare instances of idiosyncrasy individuals may develop syncope or cardiovascular collapse and death from the absorption of extremely small amounts of these drugs. The treatment of toxic side effects involves the prophylactic or therapeutic administration of short acting barbiturates to prevent or treat convulsive signs and the use of stimulants, vasoconstrictors and artificial respiration in cases of cardiovascular collapse. The local anesthetics are rapidly absorbed from injection sites and fairly rapidly detoxified by hydrolysis of their ester linkage. Cocaine alone of these drugs has local vasoconstricting properties, but the addition of epinephrine in concentrations of 1:50,000 to 1:200,000 to any of the local anesthetics will prolong their duration of action and decrease their toxicity by slowing absorption from the site of injection.

METHODS OF LOCAL ANESTHESIA

1. Surface anesthesia. Aqueous solutions of the salts of commonly used local anesthetics do not penetrate the intact skin. Their bases in ointments do penetrate to a limited extent and have been applied to wounds for the relief of pain. However, this is not advisable inasmuch as the resultant tissue damage may delay healing. Topical application of those agents which penetrate the mucous membranes is the commonest method of producing anesthesia of the bladder, urethra, nose and throat and cornea of the eye.

2. Infiltration anesthesia brings the drug into direct contact with the nerve endings. Injections may be made intradermally with a 27 gauge needle into a small skin area in order to facilitate the introduction of larger needles used for transfusions or spinal puncture. Injection may also be made deeper into the subcutaneous tissues in a ring about the site of operation to block all sensory nerve endings in this area.

3. Block anesthesia refers to the direct introduction of the anesthetic onto a nerve trunk supplying the operative area. This may be a small peripheral nerve, such as the mandibular, or may include the large nerves emerging from the spinal cord. Special types of block anesthesia include: paravertebral block, spinal anesthesia, epidural anesthesia, transsacral block and caudal anesthesia.

LOCAL ANESTHETICS IN GENERAL USE

Cocaine is the ester of benzoic acid and a nitrogen containing base, ecgonine. It has local vasoconstricting properties and need not be used with epinephrine which, however, prolongs its action. Cocaine penetrates intact mucous membranes readily and despite its toxicity and habituating or addicting properties, it is still much used in eye, ear, nose and throat surgery. (*Continued on Page* 104)

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In the eye, cocaine causes dilatation of the pupil and irritation and pitting of the cornea and for this reason has been largely replaced by tetracaine (pontocaine). Centrally, cocaine causes excitement, a sense of well-being, a feeling of great physical strength and omnipotence, and, if its use is continued, as in addicts, causes dangerous paranoid delusions. *Cocaine is never injected* for anesthetic purposes. It is only used topically.

Butacaine (butyn) is the para amino benzoic acid ester of dibutyl amino propanol. Similar in structure to procaine, it is as potent and as toxic as cocaine. Like cocaine, butacaine is used only as a topical anesthetic.

Procaine (novocaine), the para amino benzoic acid ester of diethylaminoethanol, is the least toxic and most widely used of the local anesthetics. It is ineffective topically and the duration of anesthesia is short (less than one hour).

Piperocaine (metycaine) is the benzoic acid ester of a base containing a methylpiperidino ring. Only slightly more toxic than procaine subcutaneously, it produces more intense and longer-lasting anesthesia on injection and is in addition slightly effective topically. It is widely used as a substitute for procaine and is especially valuable where sensitivity to procaine exists either in the doctor or the patient.

Tetracaine (pontocaine) is the para-butyl-amino benzoic acid ester of dimethylaminoethanol. It is 10 to 15 times as toxic and as potent as procaine. It is thought by some investigators to have a higher therapeutic ratio than procaine and although used mostly for spinal and topical anesthesia in the past, it is being used more and more in low concentrations for infiltration anesthesia since its duration of action is from two to four times longer than that of procaine.

Dibucaine (nupercaine) is a quinoline derivative with an amide rather than an ester linkage. It is the most potent of the local anesthetics and also the most toxic. It is about 20 times as potent and toxic as procaine with a therapeutic ratio of about 1, but with greatly prolonged effect. Except in very dilute solutions it is irritating to tissues and has been primarily used for topical and spinal anethesia.

Benzocaine and Butesin. These two compounds, the para amino benzoic acid esters of ethanol and butanol respectively, are representatives of a large group of local anesthetics of high potency but extremely low solubility. They are used topically as dusting powders and ointments on burned and scarified skin.

Lidocaine (xylocaine) ω-diethyl amino-2, 6-dimethyl-acetanilide, a new local anesthetic introduced in Sweden in 1948 by Nils Lofgren, has had extensive clinical trial in this country. It is only slightly more toxic but is more potent than procaine. It is more rapid and long lasting in effect than procaine, and is said to be the most stable of local anesthetics. If the glowing reports on lidocaine continue, it may well replace procaine.

The clinical use of local anesthetics has become remarkably diversified since their introduction as surgical adjuncts. Today they are used for the alleviation of painful syndromes of all types. They are infiltrated around painful inflamed joints and muscles. Injected in the region of the paravertebral sympathetic ganglia they subserve both therapeutic and diagnostic purposes.

(*Continued on Page* 106)

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INTRAVENOUS INJECTION

Within five years of its introduction in 1905, procaine had been given intravenously for its analgesic effect. This procedure was thought to be extremely hazardous and was avoided until 1935 when various investigators began to report independently on the use of intravenous procaine for the production of analgesia in painful states. The slow intravenous injection of procaine in amounts up to 1 gm. was shown to produce extremely effective relief of pain, itching and muscle spasm.

In 1940, the ability of procaine to prevent and reverse the cardiac arrhythmias induced by cyclopropane anesthesia was first noted. Since this time, there has been wide acceptance of the use of this drug intravenously prior to operative manipulation of the heart because of its quinidine-like property of decreasing cardiac irritability and preventing arrhythmias. These general effects of procaine are shared by the other local anesthetics and lidocaine and piperocaine have been similarly employed. These drugs are more toxic, however, and are ineffective orally. In 1949 Rovenstein, et al, reported on a new compound, procaine amide (Pronestyl) synthesized by W. H. Lott of Squibb, which has the structure of procaine except for the replacement of the ester linkage with an amide linkage. This compound is much more slowly hydrolyzed than is procaine and it is effective both intravenously and orally in just the same manner as quinidine is.

PREVENTION OF FATAL ERRORS

It is recommended that:

1. Cocaine and butacaine be used for surface anesthesia only.
2. The total amount of cocaine used be not over 0.1 gram.
3. Procaine as an injection anesthetic be used in a 0.5 to 1 per cent concentration.
4. No injection be made into the urethra if there is trauma, inflammation or stricture.
5. The spoken words "cocaine" and "procaine" should not be confused.

It should also be remembered that: (1) the dose of all drugs is not one ampule; (2) the patient should be questioned about his sensitivity to the drug; (3) the solution should be smelled and tasted; (4) ampules should be stored in alcohol colored with eosin. — HARRY L. WILLIAMS, M.D.

Conducted by Mary P. Huddleson

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on the cafeteria tray conveyor

L. E. RICHWAGEN

Administrator, Mary Fletcher Hospital
Burlington, Vt.

Conveyor extends into the cafeteria 16 feet and operates through a slot in the wall. A door separates cafeteria from cleanup room. This door is kept closed during meal hours.

THE conveyor belt, symbolical of straight-line production in industry, also can be used to bring about efficiency and cut down confusion in the hospital cafeteria.

When we built our new hospital building at Mary Fletcher Hospital, Burlington, Vt., we installed a conveyor belt to carry trays of soiled dishes from the dining area to the clean-up room and we think it was one of the smartest things we did.

Actually, there is nothing startling about the use of a conveyor belt. The surprising aspect is that more hospitals do not make use of this simple mechanism for this purpose.

When we were planning our new building (into which we moved a year ago), we followed the traditional pattern and visited a large number of newly constructed hospitals so as to profit from what they had done. We were impressed by the fact that many hospitals had not solved satisfactorily the problem of disposing of soiled dishes.

Attractive dining rooms were thrown into confusion and clutter by trayload upon trayload of dirty dishes. We noted overloaded tray racks with garbage spilled onto the floor. In one beautiful new dining area, we gazed with concern as trays were placed perilously upon trays in the pass window while tired employes on the other side fought a losing battle to keep up with the workload. In still another hospital cafeteria, conscientious personnel utilized the floor along the wall to set down the trays because there was no other place to put them. The administration of one hospital apparently surrendered to the inevitable, allowed employes to leave their soiled dishes on the tables, and employed additional personnel to do the cleaning up, while diners sought out the clean tables at which to eat.

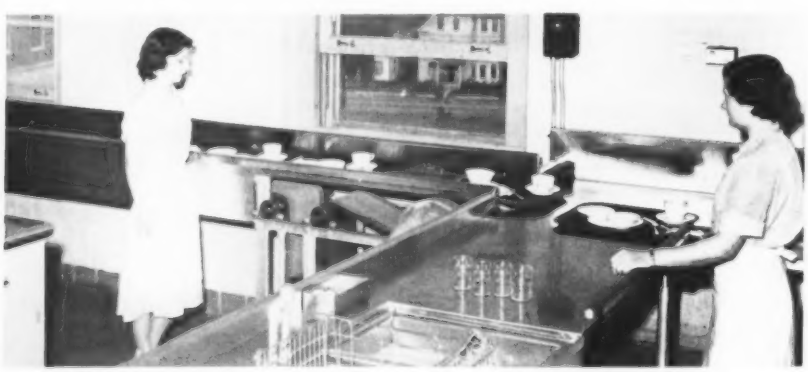
All of this seemed unnecessary.

We asked ourselves some questions.

How did the large, successful eating establishments handle this problem?

What would industry do about a bottleneck like this?

We found our answer quite easily once we became curious. There were



The conveyor belt moves only as fast as trays are removed. At the end of the conveyor glasses are separated from dishes and go in a different direction. During peak loads, two persons can stand at the end of the belt and unload the trays of dishes.

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JOHN SEXTON & CO., CHICAGO, 1954

large restaurants using the conveyor belt and, we were told, it "never" broke down. It carried away the soiled dishes without confusion and in a steady stream that provided a fairly constant workload for the clean-up crew. Our industrial friends confirmed our belief that we could gain efficiency in our cafeteria with a conveyor belt.

In spite of the fact that the conveyor belt is a simple device, there was some eyebrow lifting when it was included in the plans, mostly, I gathered, because these plan-studiers had not heard of one being installed in a hospital cafeteria.

Our conveyor is 28 feet long and can accommodate 20 trays at one time. As long as trays are being removed in the clean-up room, the belt continues to move.

We serve an average of 275 to 300 persons at the noon meal, but sometimes the number runs to 320. We employ two full-time and one part-time persons in the clean-up room. These employes unload the conveyor belt without additional assistance unless there is an unusually large number of trays being brought to the conveyor within a short time. In that case, one of the employes on the serving counter is delegated to help unload the conveyor.

In our dining room setup, all hospital personnel — service workers, nurses, student nurses, house staff, attending staff and office personnel— eat in the same dining area and go through the same cafeteria line. Incidentally, we have no clamor for separate dining rooms. Each person is expected to remove his soiled dishes on a tray and place it on the conveyor. While we thought that we might have some initial difficulty in putting this system into effect, the system worked perfectly right from the start. The fact that the conveyor was a novelty and diners liked to see their dishes move out of the area silently and expeditiously had something to do with getting the system off to a good beginning. For more than a year now, there have been no failures of personnel to remove soiled dishes. Even when a doctor or nurse is called out in an emergency, someone else picks up the tray and carries it away.

The conveyor belt has many direct and indirect advantages.

Direct advantages include:

1. No piling up of dishes and trays at a pass window or on tray trucks.
2. Trays and dishes are removed inconspicuously to a soundproofed clean-up area.
3. No clatter, confusion and noise while workers try to get trays and dishes away from the entrance to the clean-up room.
4. Elimination of need for bus boys to clear off tables.
5. Tables always ready for new diners.
6. Workers in clean-up room have a steadier flow of trays and a backup margin which is the length of the conveyor belt.

Indirect advantages include:

1. Lack of confusion makes the dining room a pleasant place to eat in. This quiet atmosphere is in keeping with the attractive furniture, draperies and color scheme.
2. Personnel takes pride in keeping tables, chairs and floor tidy.

We like our cafeteria tray conveyor. We believe many hospitals might advantageously look into the use of a conveyor to break bottlenecks in removal of soiled dishes. The advantages are many and as yet we have not found any disadvantages.

Now you can handle all 3

★ SELECTIVE MENU SERVICE
★ SPECIAL DIETS
★ WARD SERVICE

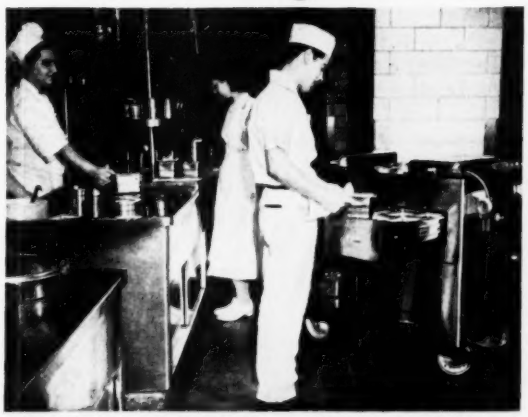
WITH ONE *All-Purpose* FOOD CONVEYOR

18 insets in six sizes allow for many variations in menus.

Model ALS-4922

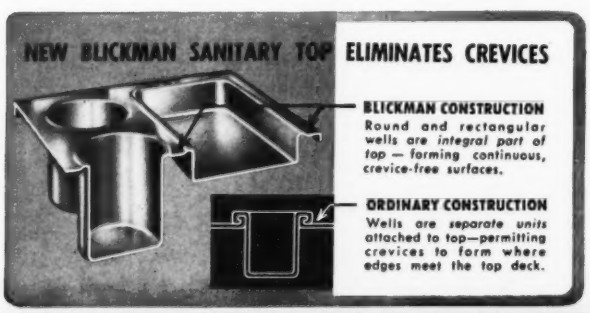
• With its numerous top-deck arrangements, the new Blickman-Built *All-Purpose* Food Conveyor is specially designed to take care of your different food service requirements. For ward service, you store the limited variety of foods in a few of the larger insets. To accommodate the more diversified foods in your selective menus and special diets, simply take out the large insets and substitute a number of smaller containers. Eighteen square and rectangular insets are provided with the conveyor in six different sizes. These can be arranged in various combinations. Two heated drawers and lower compartments add to the ample storage space provided in the top deck.

You obtain these additional advantages: Food is kept piping-hot; arrives on time, in kitchen-fresh, palatable condition – important factors in diet-therapy. You save time and labor, waste less food. Since food is transported in bulk, fewer trips are required, dish and tray trucks are eliminated. Cleaning, too, is a swift and easy task. Blickman-Built stainless steel food conveyors are the only standard models available with one-piece, crevice-free body and seamless top-deck construction. These, and other important aids to mass-feeding efficiency are yours—when you use Blickman-Built *All Purpose* Food Conveyors – the finest made.



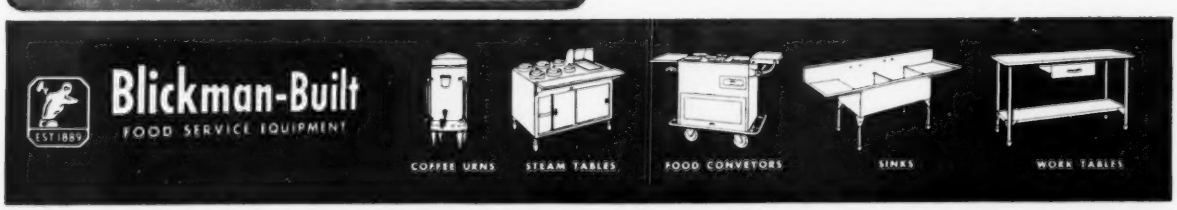
367-bed Beth Israel Hospital, of Boston, Mass., serving 70,000 meals per month, of which 30,000 are patient meals, has found an effective solution to their mass-feeding problem in the Blickman-Built *All-Purpose* Food Conveyor. Illustration shows truck being loaded in main kitchen. Conveyors distribute hot foods to serving pantries on each floor.

At Stamford (Conn.) Hospital, conveyor carries bulk food from central kitchen to serving kitchens on each floor. Shown here is nurse carrying loaded tray from serving kitchen after it has been loaded on *All-Purpose* Food Conveyor. Patient gets the food hot and appetizing.



Send for illustrated folder
explaining merits of the *All-Purpose* Food Conveyor and describing this and other Blickman-Built Food Conveyors.

S. BLICKMAN, INC.
1505 Gregory Avenue Avenue, Weehawken, N.J.



You are welcome to our exhibit at the Catholic Hospital Association Convention, Convention Hall, Atlantic City, N.J., Booths No. 536-40-42, May 17-20, and to the Middle Atlantic Hospital Assembly, Convention Hall, Atlantic City, N.J., Booths No. 301-303, May 26-28.

An answer to the problem of

Ice Containers for Milk Mixes

LARRY NELSON
Director of Food Service
Wesley Memorial Hospital, Chicago

FOR many years we have been searching for a suitable container for milk mixes to be used for patients on ulcer diets. The conventional quart size vacuum container has been recommended and is used by many hospitals today. However, we experimented with this type of container and found several objections to its use:

1. It is difficult to clean and sterilize after each filling.
2. Individual cost is rather high.
3. Containers are lost through theft.
4. Temperature control is not satisfactory when containers are opened and closed after each feeding.
5. Filling containers is time consuming and messy.

From a cost standpoint we have gone along using the universal method of supplying a china flower vase, conical in shape, and inserting ice cubes around the bottle of milk mix, in the center of the vase. Temperature control has been rather good but fresh ice cubes are needed constantly during the feeding period; after each feeding the bottle of mix is removed to be poured into a measuring glass and, of course, the ice cubes in the vase rush to the center and it is quite a task to return the bottle to its original position. Toweling is usually put under the vase to catch condensation and polished wood surfaces are ruined if the container is placed on them. The top of the vase is open and this of course tends to make ice melt quickly in high temperatures. Today, many patients are permitted to take feedings during the night and one can readily see the difficulties that would be encountered by a patient.

Sometime ago I entered the hospital as a patient to undergo surgery. During my stay I was fortunate to have a patient in my room who was on an ulcer diet and I had the opportunity to witness the complete procedure in connection with the use of our milk mix container, in the form of the "china flower pot." I was determined to develop some better way to take care of milk feedings for ulcer patients and the result is shown in the accompanying photographs.

We have had one dozen of these containers in service on an experimental basis and they are the best solution we have found to date.

Advantages as we have found them are as follows:

1. The containers can be cleaned and sterilized through our regular dishwashing machine process.
2. After being cleaned they are inserted in large kraft paper bag, stapled and stored until called for.
3. Control is maintained easily. When the containers are returned by the nursing department, the dietitians check numerically all containers in service.
4. Usually two fillings of ice cubes are sufficient for the period of use during the day.
5. Condensation is at a minimum: aluminum is a wonderful conductor of heat and cold. Space around the milk bottle seems to create a vacuum that pulls cold temperature toward the center, keeping the mix at an even temperature.
6. The ice cubes are covered by a removable lid.
7. The container is neat in appearance and shows no telltale finger impressions.
8. The unit has been accepted enthusiastically by the nurses who agree that it is a great improvement over our old method. Best of all, the cost is low.
9. It can be used equally well for fruit juices and other feedings.

We have used these containers for three months and they have been standing up beautifully. We like them.

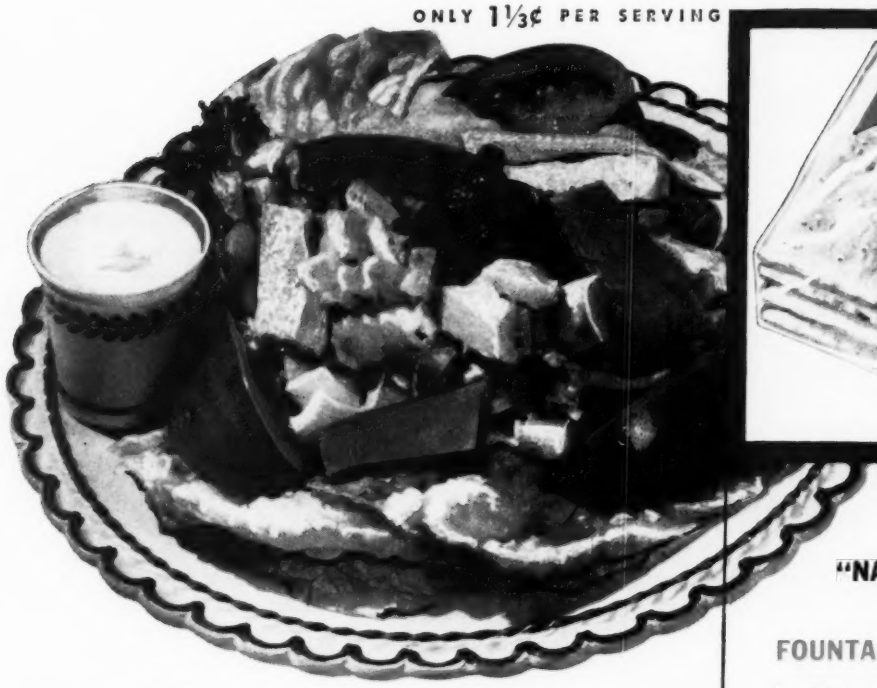
The container is so designed that milk formula can be kept chilled without the usual melting of ice and resulting spillage. Cover keeps ice in place.

PREMIUM SALTINE CRACKERS*

baked by NABISCO

delicious with salads!

ONLY 1⅓¢ PER SERVING



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FOOD FOR THOUGHT

Ham Language

What is meant by "tendered," "ready-to-eat," "fully cooked" ham? Food specialists in the U.S. Department of Agriculture offer the following explanations:

All cured and smoked hams prepared under federal meat inspection are required—by a regulation first put into effect in 1952—to be heated to at least 137° F. internal temperature, or else treated by approved methods of freezing or drying and curing that will make sure no live trichinae remain in the meat. Thus, any cured, smoked ham marked with the round purple U.S. inspection stamp does not need to be cooked for health safety precautions, only for good eating. Much of the cured, smoked ham on the market now is safeguarded this way, since federal inspection is required for all meat sold across state borders.

Federally inspected hams labeled "tender" (or "tendered" or "tenderized"), "ready-to-eat," or "fully cooked" must all have been heated beyond 137° F.—to an internal temperature of 140° F. at least. A "tender" ham, while partially cooked, needs some additional cooking to give it a well-done texture and full ham flavor. The packer's label usually offers directions for this, adjusting them to the amount of heating his company gives to such ham.

A "ready-to-eat" ham may be served without further cooking, if desired. However, some are more thoroughly cooked than others, and many people prefer in any case to give this type of ham some additional cooking for best flavor and texture.

"Fully cooked" hams have been heated in processing to the point at which they have "a fully cooked appearance throughout"—which is a requirement of the federal meat inspection service for any ham so labeled. Such hams need no more cooking, unless to be served hot.

More information about pork, such as varied forms in which it is marketed, and economic and quality factors that figure in a good buy, is included in a new publication, "Pork . . . Facts for Consumer Education," AIB-109, prepared in the Department of Agriculture, available from the Superintendent of Documents, U.S. Government Printing Office, Washington, 25, D.C.

Peanuts and Peanut Butter

Just in time to go along with peanuts and peanut butter, both on the current list of "plentifuls," is a newly revised collection of more than three dozen recipes for these foods which points out the virtues of the nut that isn't really a nut at all, but a member of the pea-and-bean family. Single copies of this Home and Garden Bulletin No. 36, "Peanut and Peanut Butter Recipes," are free on request to the Office of Information, U.S. Department of Agriculture, Washington 25, D.C.

Peanuts have long been popular in salads, sandwiches, cookies and desserts, but are also good in main dishes, in soups, and in combination with other vegetables. Peanuts and peanut

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- ***High patient preference***
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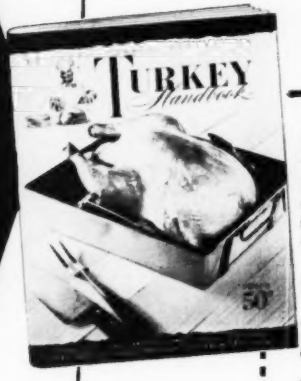

NATIONAL TURKEY FEDERATION
Mount Morris, Illinois

Single copies of "Turkey Handbook" free to food buyers, chefs, dietitians of hotels, restaurants, clubs, hospitals, schools and other food-serving institutions. Send for your copy on company stationery.

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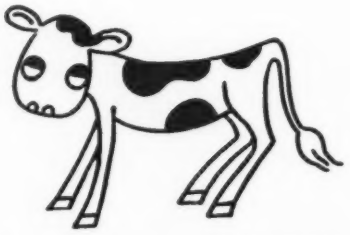
butter are a good source of food energy and of B vitamins and protein.

Included in the bulletin are recipes for main dishes, for peanuts with vegetables, for peanuts and peanut butter in breads, for salads and relishes, salad dressings, soup, desserts, and sweet sauces. One of the six main dishes is peanut butter French toast, made as follows:

½ cup peanut butter
¼ cup honey
¼ teaspoon salt
8 slices bread
2 eggs, beaten
½ cup milk
2 tablespoons butter or margarine

Blend peanut butter, honey, and salt. Place about 2½ tablespoons peanut butter-honey mixture between 2 slices of bread to make a sandwich. Combine eggs and milk. Soak sandwiches in egg mixture. Melt butter or margarine in a baking pan or fry pan. Bake sandwiches at 400° F. (hot oven) about 40 minutes. Turn sandwiches to brown both sides. Or cook slowly in fry pan on top of range. Four servings.



THE COMPLETE MEAT COOKBOOK. *By Beth Bailey McLean and Thora Hegstad Campbell. Peoria, Ill.: Chas. A. Bennett Co., Inc., Pp.* 559, *Price,* $4.95.

Here at last is a book that will make every dietitian wonder why no one attempted it before—inasmuch as meat takes priority on the American table from the standpoint of taste appeal, nutritional value, and budgetary allocation.

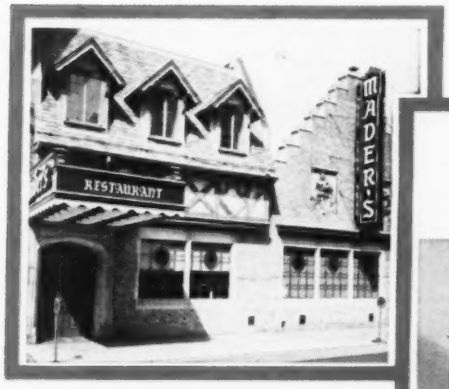
As the authors state in their preface to the book, "you're right in liking meat" with its complete protein roster of 10 essential amino acids, its B vitamins, its minerals. Yes, "if the meat is right the meal is right" and the importance of this book is further attested when one realizes that the roughly more than 1500 recipes have been selected as the best of the vast collection that has been compiled by two recognized authorities of long experience.

Well over 200 illustrations enliven the book and serve to teach that it's not only the preparation but the final *appearance* on the serving dish which must be taken into account. Buying, carving, storage, pressure cooking, freezing, barbecuing, even the modern revival of grandmother's chafing dish—all of them have received due attention.

There's a chapter on casseroles and other combination dish cookery, on herb and spice cookery, appetizers, garnishes, on foreign cookery. It may be carping but I at least would have liked to see the delectable Cornish pastie under the foreign meat-dish entries.

Other noteworthy features are the sections on sauces and gravies, stuffings for meats and poultry, and "entertaining many"—this last section includes the only "large quantity" recipes in amounts to serve 12, 25 and 50 people. In fact we feel that many dietitians will decide that the 31 pages on the ubiquitous ground beef and the 21 on the sandwich alone are worth the price of this very welcome book.—MARY P. HUDDLESON.

TWO GREAT NAMES...



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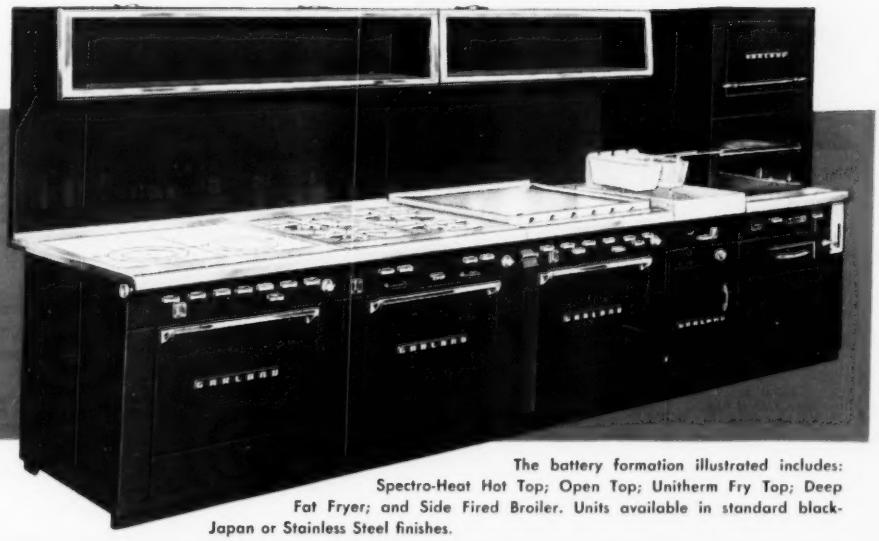
Head chef, Katherine Mader, says: "I really appreciate Garland's rugged construction and flexibility! There's no doubt about it, Garland and gas certainly do the best job of cooking!"



The battery formation illustrated includes: Spectro-Heat Hot Top; Open Top; Unitherm Fry Top; Deep Fat Fryer; and Side Fired Broiler. Units available in standard black-Japan or Stainless Steel finishes.

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Menus for June 1954

Henry Vigdor
Executive Dietitian
Mount Sinai Hospital
Hartford, Conn.

1 Orange Juice Poached Egg on Toast • Vegetable Soup Hamburger on Bun French Fried Potatoes Lettuce and Tomato Salad Apple Cobbler • Grape Juice Baked Shoulder Lamb Chops Buttered Rice Peas Chocolate Cake	**2** Orange Juice Scrambled Eggs, Bacon • Cream of Mushroom Soup Hot Beef Sandwich With Gravy Tossed Green Salad, Dressing Peach Shortcake • Apple Juice Braised Liver Parsley Potato Kernel Corn Julienne Green Beans Banana Gelatin	**3** Stewed Prunes Soft Cooked Eggs, Muffin • Tomato Bouillon Turkey Pie, Cornbread Lettuce Wedge, 1000 Island Dressing Cherry Pie • Pineapple Juice Baked Ham Mashed Sweet Potato Julienne Green Beans Celery Hearts Pear Halves	**4** Orange Juice Griddle Cakes, Sirup • Vegetable Soup Tuna-Noodle Casserole Asparagus Spears Molded Fruit Salad Ice Cream • Fruit Cup Halibut Steak, Lemon Wedge Baked Potato Carrot Quarters Sponge Cake	**5** Orange Juice Poached Egg, Toast • Chicken Soup Beef-Biscuit Roll Chef's Salad, Dressing Pound Cake • Tomato Juice Roast Leg of Veal, Gravy Buttered Noodles Spinach Butterscotch Pudding With Whipped Cream	**6** Orange Juice Scrambled Eggs, Roll • Apricot Nectar Rib Roast of Beef au Jus Oven Browned Potato Peas Celery and Olives Strawberry Sundae • Cream of Vegetable Soup Cold Plate: Tuna Salad, Potato Chips, Sliced Tomato, Pickles Cookies
7 Kadota Figs French Toast, Sirup • Consommé Baked Macaroni and Cheese Broccoli Spears Peach and Prune Salad Gingerbread With Hard Sauce • Grapefruit Juice Swiss Steak Mashed Potatoes Paprika Cauliflower Date-Nut Pudding	**8** Orange Juice Soft Cooked Egg, Muffin • Beef Noodle Soup Hot Corned Beef on Rye Bread Potato Salad Coleslaw Blueberry Pie • Apple Juice Roast Chicken, Gravy Sweet Potato-Apple Escallop Wax Beans Cranberry Sherbet	**9** Orange Juice Poached Eggs, Toast • Tomato Soup Codfish Sticks, Tartare Sauce Mashed Potatoes Peas Gelatin Jewels • Grape Juice Salmon Steak Baked Potato Spinach Assorted Relishes Iced Angel Food Cake	**10** Citrus Sections Scrambled Eggs, Muffin • Cream of Vegetable Soup Salisbury Steak, Gravy Parsley Potato Mixed Vegetables Cherry Tarts • Tomato Juice Roast Loin of Pork With Gravy Mashed Potatoes Green Lima Beans Apple Brown Betty	**11** Orange Juice Griddle Cakes, Sirup • Clam Chowder Grilled Cheese Sandwich Asparagus Spears Peach-Cherry Salad Chocolate Sundae • Apricot Nectar Cold Plate: Salmon Salad on Lettuce, Deviled Eggs, Tomato Wedges, Stuffed Olives Lady Baltimore Cake	**12** Prune Juice Soft Cooked Egg, Muffin • Julienne Consommé Beef Turnovers Broccoli Tossed Green Salad • Elberta Peach Halves, Pineapple Juice Baked Meat Loaf With Vegetable Sauce Buttered Rice Quartered Carrots Tapioca Cream Pudding
13 Orange Juice Poached Eggs, Muffin • Grape Juice Southern Fried Chicken Candied Sweet Potato Kernel Corn Cranberry Relish Salad Ice Cream, Cookies • Beef Vegetable Soup Cream Chipped Beef and Mushrooms on Rusk Broiled Tomato Sliced Pineapple	**14** Orange Juice Scrambled Eggs, Toast • Chicken Bouillon Cottage Cheese and Fruit Salad Hot Rolls Graham Cracker Pudding • Fruit Cup Broiled Ham Steaks Oven Browned Potato Brussels Sprouts Gelatin	**15** Grapefruit Half French Toast, Sirup • Tomato Soup Turkey Croquettes, Fricassee Sauce Mashed Potatoes Chef's Salad Blueberry Pie • Apple Juice Pot Roast of Beef With Gravy Buttered Noodles Spinach Purple Plums	**16** Orange Juice Soft Cooked Eggs, Roll • Cream of Corn Soup Sandwich Steaks French Fried Potatoes Sliced Tomatoes Vanilla Pudding With Strawberry Sauce • Pineapple Juice Roast Leg of Lamb Parsley Potato Carrot Pennies Pound Cake With Chocolate Sauce	**17** Orange Juice Poached Eggs, Roll • Celery Broth Baked Macaroni and Cheese Julienne Green Beans Banana Fan Salad Ice Cream • Apricot Nectar Beef Stew on Biscuit Chef's Salad Apple Pie	**18** Orange Juice Scrambled Eggs, Toast • Cream of Corn Soup Shrimp Creole Buttered Rice Perfection Salad Peach Cobbler • Tomato Juice Halibut Steak With Egg Sauce Mashed Potatoes Whole Beets Cup Cake
19 Grapefruit Juice Griddle Cakes, Sirup • Chicken-Rice Soup Frankfurter Baked Beans Combination Vegetable Salad Jelly Roll • Apple Juice Roast Loin of Pork With Gravy Chow Chow Mashed Potatoes Peas Lemon Meringue Pudding	**20** Orange Juice Poached Eggs, Roll • Cranberry Juice Broiled Steak Mashed Potatoes Whole Carrots Spiced Crabapple Sherbet • Vegetable Broth Cold Plate: Turkey Salad, Macaroni Salad, Sliced Tomato, Pickles Spice Cake	**21** Prune Juice Soft Cooked Eggs, Toast • Russian Beet Soup Swedish Meat Balls on Italian Spaghetti French Bread Greek Salad Indian Pudding • Grape Juice Breaded Veal Cutlet Parslied Potato Cut Green Beans Marble Cake	**22** Citrus Sections Bacon Curls, Muffin • Mulligatawny Soup Hot Meat Loaf Sandwich, With Gravy Mixed Vegetables Lettuce Salad Strawberry Shortcake • Pineapple Juice Country Style Steaks Buttered Noodles Broccoli Spears Sliced Peaches	**23** Orange Juice Scrambled Eggs, Muffin • Cream of Pea Soup Veal Scallopini, Biscuit Tossed Green Salad Blueberry Cobbler • Fruit Cup Roast Duck, Gravy Raisin Dressing Mashed Potato Cauliflower Fruited Gelatin	**24** Orange Juice French Toast, Sirup • Chicken Vegetable Soup Baked Macaroni and Cheese Fruit Salad Boston Cream Cake • Grape Juice Baked Shoulder Lamb Chops Escalloped Potatoes Wax Beans Pear Halves, Cookies
25 Orange Juice Soft Cooked Eggs, Toast • Corn Chowder Codfish Cakes, Sauce Mashed Potatoes Tossed Vegetable Salad Ice Cream • Tomato Juice Fillet of Sole, Tartare Sauce Paprika Potato Coleslaw Butterscotch-Nut Pudding	**26** Stewed Rhubarb Poached Eggs, Muffin • Julienne Consommé Beef Pie, Hot Roll Asparagus Pineapple Upside Down Cake • Apple Juice Roast Leg of Veal, Gravy Steamed Rice Brussels Sprouts Fruit Cocktail	**27** Orange Juice Scrambled Eggs, Roll • Blended Juice Roast Tom Turkey Bread Dressing Mashed Sweet Potatoes Peas Cranberry Sauce Ice Cream Sundae • Cream of Mushroom Soup Egg Salad Sandwich Lettuce and Tomato Salad Kadota Figs	**28** Orange Juice Soft Cooked Eggs, Roll • Beef Noodle Soup Hamburger on Roll, Relish French Fried Potato Cabbage Salad Lemon Meringue Pie • Vegetable Juice Beef à la Mode Mashed Potatoes Carrot Curls Ripe Olives Sponge Cake	**29** Orange Juice Griddle Cakes, Sirup • Scotch Broth Cold Plate: Corned Beef, Potato Salad, Cucumber Sticks, Pickles Apple Brown Betty • Pineapple Juice Broiled Chicken Stuffed Baked Potato Baby Lima Beans Orange Snow	**30** Orange Juice Poached Eggs, Muffin • Beef Rice Soup Irish Lamb Stew Tossed Green Salad, Dressing Cherry Pie • Grapefruit Sections Baked Ham, Gravy Parslied Potato Cauliflower Sherbet

Ready-to-eat or cooked cereals are offered on all breakfast menus.

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To brighten up tray service, to lighten cost burdens, look to embossed paper tray covers like "Rose Linen", another popular design by Milapaco. This attractive tray cover, with matching doily, faithfully simulates in paper the delicacy and texture of real linen.

In linen — or any of many distinctive lace or stock and special print designs — Milapaco tray covers add welcome "meal appeal" to hospital tray service . . . always fresh, clean and sanitary . . . used once and discarded to reduce contamination . . . extra soft to prevent sliding, absorb spillings and reduce noise from the clatter of china and utensils.

A proven economy, too, Milapaco tray covers cost but penny-fractions per serving . . . come in a wide range of sizes to fit any tray . . . cut linen costs . . . reduce laundry-labor expense . . . save wear on trays . . . speed up service . . . and store compactly.

The happy touch for the patient — and the dietitian and purchasing agent, too — Milapaco tray covers are indeed a "preferred stock." And for all your specialty needs, look to the famous Milapaco family, a complete dependable source of quality specialty paper products.

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A consultant casts an appraising eye on the problems and possibilities of

Air Conditioning in Hospitals

CHARLES F. NEERGAARD
Hospital Consultant
Neergaard, Agnew, Craig and Westermann, New York City

A draft of this article was submitted to 23 architects, engineers, manufacturers, public health and hospital authorities. Comments received were generally most favorable. Several suggested that in the South and other high-temperature areas, hospitals were increasingly accepting air conditioning as a "must," which only emphasizes the author's thesis that simplification of the plant and its operation and deflation of the costs are imperative.

One challenged the statement that air conditioning had no therapeutic value and suggested that certain clinical conditions—heart failure, fevers, enteric diseases—were adversely affected by high temperature and humidity. But these conditions do not justify air-conditioning the entire building, as a portable cooler may be brought to patients as readily as is an oxygen tent.

THE phenomenal growth of air conditioning in the past decade and its wide acceptance by the public raises the question as to whether, when a new hospital is being planned, air conditioning should not be included or at least provided for.

Air conditioning has obviously arrived, as almost an essential of modern living. A new hotel, office building or store is obsolete without it. It is featured in trains and planes, ocean liners and automobiles, and even in the *Saturday Evening Post*. Owners of old buildings are spending millions to install it. Their advertisements carry "Completely air conditioned" at the masthead.

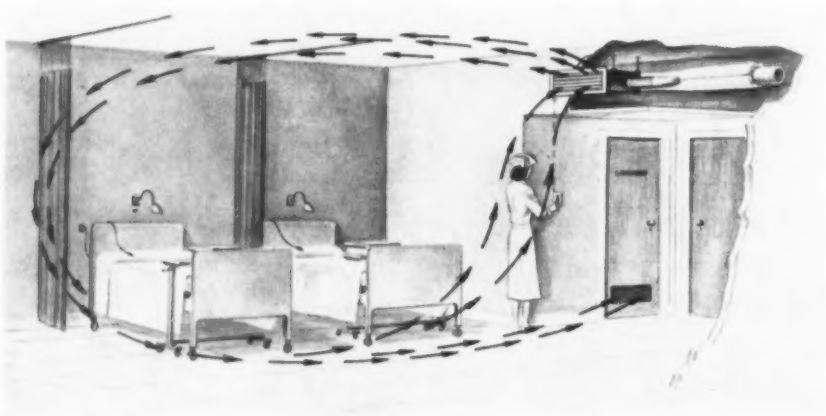
The air conditioning industry in the United States sold 340,000 room coolers in 1952 and expected to sell 600,000 last year. The building industry erected 15,000 new homes in 1952 designed for summer cooling and expected to build 60,000 in 1953. If the public is willing to pay for comfort and the employer gains in efficiency and better personnel relationship, the cost factor becomes secondary. Surveys of commercial users indicate that increased business follows the installation of air conditioning. Department stores report gains of 10 per cent in sales; food markets, 31 per cent; beauty parlors, 33 per cent, and barber shops 25 per cent.

What is this air conditioning—what does it do, how does it work, what does it cost? To the average man it means a cool room on a hot day in summer but now we have it the year round.

For generations in winter we have put on the storm sash and turned on the heat and in summer put up the screens, opened the windows, and turned on the fans. But now we keep the windows closed and simply turn valves and push switches.

Modern air conditioning performs four functions: (1) controls temperature, (2) controls humidity, (3) removes dust (filters), and (4) controls air movement.

In moderate weather, working conditions can be improved in a building by air movement and by filtering out dust. Controlling temperature alone is not sufficient to produce comfort without controlling humidity and that



Drawing by Anemostat Corporation.

Diagram of air circulation with high velocity dual duct system for heating and cooling, with induction unit on corridor side of room. Given insulated walls and double glazed windows, the building can be heated satisfactorily without direct radiation in almost all areas.

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Floors Can Shine with a Layer of Safety

Floors are safer to walk on, safer to work on when the wax used on them contains Du Pont "Ludox" colloidal silica. Such floor waxes give unbeatable anti-slip protection to employees and clients, to guests and visitors.

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BETTER THINGS FOR BETTER LIVING . . . *THROUGH CHEMISTRY*

E. I. du Pont de Nemours & Co. (Inc.)
Grasselli Chemicals Department
Wilmington 98, Delaware

is a major factor in air conditioning. Humidity makes cold pipes sweat and hot people perspire. If 100 people are dancing in a room temperature of 75°F., they will perspire 5 gallons of water an hour; if 100 people are gathered in a room, they will produce heat of 12 kilowatts when relaxed, 15 kilowatts when eating, and 30 kilowatts when working. (A kilowatt of heat is equivalent to approximately 3400 Btu.'s an hour.)

Research has determined various physiological factors that govern comfort. In summer when the outside air is cool, the heat produced by people, lights and sunshine can be removed by ventilation if handled in such a way as to avoid harmful drafts. When the outside air is warm and humid, comfort cooling is necesary to remove the heat produced in the room and to remove the excess humidity in the ventilated air and the humidity produced by perspiration of the occupants.

The average person is not uncomfortable in a temperature as high as 78°F. provided the humidity is below 50 per cent; with humidity reduced to 30 per cent the average person is at the same degree of comfort at 82° F.

Physiologic research has established the optimum condition for comfort at 76° F. and 50 per cent relative humidity, which modern design attempts to maintain in air conditioned space. So long as a person is in controlled conditioned space, the outside temperature has no bearing, but when he goes outside to a temperature of 90° or 100° F. there may be discomfort although research has been unable to determine that there is any detrimental physical effect.

The foregoing indicates the major engineering problem of air conditioning — maintaining proper controls so that comfort is ensured with the rapid changes in temperature and humidity that are frequent in many climates.[1] It oulines in layman's language the ideal in artificial climate conditions, which the engineer attempts to achieve in the design of his plant when he substitutes standardized man-made weather for nature's untamed vagaries.

It is suggestive of the many complex technical problems of controls which must be designed to react promptly to the rapid changes in temperature and humidity during the four seasons and which can be adapted to individual demands for more or less heat or cold in all parts of a building at all times. It does not touch on many important factors: the plant and method for the generation of heat and cold; their distribution throughout the various zones of the building by pipes or ducts or both; the control of humidity; the large ventilating fans for supply, exhaust and recirculation of air, all of which must be in proper balance at all times to ensure proper air volume and velocity, with control of noise and vibration. (These are a *must* in a hospital.)

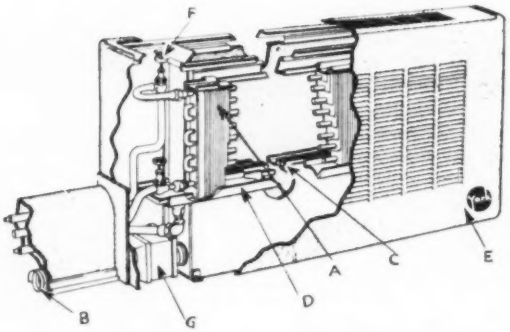
Verily, an air conditioning system is a challenging problem of engineering design, costly to install and, when finished, a most difficult plant to operate economically and to keep in perfect adjustment.

Fifteen years ago Willis Carrier, the father of air conditioning, wrote: "A general survey of air conditioning systems seems to indicate that the faults lie primarily in operation." Today the same seems equally true.

With the tremendous demand, many new makes of room units have come on the market, many of them excessively noisy and poorly designed. Innumerable badly engineered central plants have been installed in old buildings, which leave much to be desired in comfort and cost.

During a Florida visit last winter I found that our hotel had been air-conditioned since our last trip. I asked the floor maid how she liked it. "It's wonderful, but of course we have to wear sweaters all the time." Our room was chilly and, as we had no sweaters, I tried to turn off the stream of cold air coming through the grille, but the valves did not respond. I sent for the engineer. He, not being clockwise-minded, said, "You gotta turn it on to turn it off." I was embarrassed. We visited 10 air conditioned places — hotels, restaurants, theaters and offices, every one of which was overchilled. Only the two architects' offices which I frequented were really comfortable.

Vastly different is the modern, scientifically engineered plant operated by trained engineers. Two new office buildings in New York — Lever House and 100 Park Avenue — exemplify air conditioning at its best. I visited them several times during the hot summer of 1953, went through the immaculate compressors and fan rooms with the competent operating staff, and dis-



CUT-AWAY VIEW, FREE-STANDING UNIT

This diagram shows the working principle of the induction room unit.

A. Coils through which hot or cold water is circulated at controlled temperatures.

B. High velocity duct supplying conditioned air, controlled in temperature and humidity, from compressor room.

C. Perforated or slotted plate introduces the conditioned air behind the coils and induces a return air flow from the room, in controlled proportion.

D. Drip pan with waste connection to carry off moisture condensed from the air on the cooling coils.

E. Panel with grille at top and bottom to admit and discharge air from and to the room. These panels are removable so that the dampness and dust can be cleaned from the coils, distributing pipe and drip pan.

F. Control of coil temperature, either manual or by automatic thermostat.

G. Damper controlling quantity and pressure of air from central source of supply, usually adjusted and balanced for each room.

[1]For these technical data I am indebted to J. S. Keenan of the Canadian General Electric Co., who kindly sent me his address to the Canadian Electrical Association in June 1953.

New, Versatile, Economical

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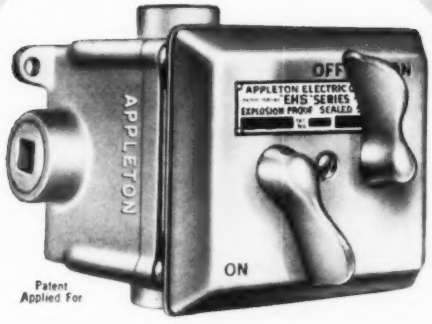
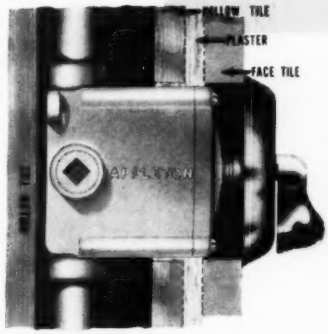
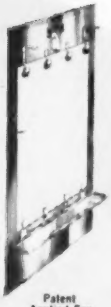


Type "EHS" Two Gang Switch
CLASS 1, Groups C and D



featuring: **An Adjustable Cover offering a range from 9/16" Min. to 1-13/16" Max. to accommodate different wall thicknesses. Also includes a Self-Leveling Adjustment.**



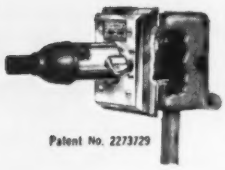
X-ray Film Illuminators for hazardous or non-hazardous locations.

Patent Applied For

Because of its adjustable cover feature, this "EHS" Series Explosion-Proof Switch is particularly suited to modernization programs. It is quickly and easily installed in walls of different plaster or tile thickness and will compensate for variations up to 5° off level.

"EHS" Series Sealed Switches are typical of *Appleton's* modern design and quality craftsmanship which characterize the entire line of *Appleton* explosion-proof hospital equipment.

Have you checked the hazardous areas in *your* hospital lately? Why not discuss with your architect or electrical contractor the urgent need for modern explosion-proof protection . . . *Appleton* protection!



Receptacle with Plug.

Patent No. 2273729

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cussed their problems of maintenance. I talked with management and tenants, a number being personal friends, and received the most enthusiastic reports of general comfort and satisfaction.

What the hospital wants to know is how air conditioning will affect the cost of its building and its operating budget. In the absence of any available hospital experience with general air conditioning, it wants suggestive comparisons with office buildings and hotels, the latter affording the closer parallel.

It is frequently argued that if hotels find air conditioning profitable, why should not the hospital have it? The answer is essentially one of dollars and sense.

The vice president of a large hotel chain stated that it is not profitable or practical to build a hotel today at a construction cost of more than $1.50 a cubic foot that would include air conditioning. General hospitals are now costing upward of $2 a cubic foot, which would probably be increased by 10 or 15 per cent if air conditioning were added.

Hotel Management advises that in the average hotel nearly 70 per cent of the floor area is income producing space—57.47 per cent in guest rooms and 10 per cent in public and private dining rooms, function and sample rooms. In the average hospital only 30 per cent of the floor space is used for patients' beds and but few patients pay full cost.

The hotel pay roll carries an average of one employe for every 3½ rooms, about half of which are double, and the national average cash wage is $1575, with the majority of the employes in the tip receiving category, tips often equaling wages. In 18 large eastern hospitals[2] the pay rolls average 1.77 employes per bed and the average cash wage is $1930, with relatively few tips.

Thus from a plant and pay-roll standpoint the hospital is heavily handicapped and furthermore — *caveat emptor* — may well learn from the sad experience of its grandfathers. At the turn of the century in most large hospitals engineers installed elaborate plenum ventilating systems, which except for summer cooling performed most of the functions of modern air conditioning. Recirculation of air from ward to ward was considered hazardous so that great volumes of fresh air were brought in, heated, washed and distributed. As every 10,000 cubic feet of air a minute requires about 40 boiler h.p. to heat it, the boiler plant had to be of huge proportions.

When hospitals found what this system cost them to run and, furthermore that it was not really needed, they took out the big central fans and put in small local blowers, but the miles of galvanized ducts, the excessive building cube in the extra high ceilings, the additional boiler capacity, all of them costing thousands of dollars, were wasted capital.

There is evidence today of considerable overdesign and overelaboration in many projected air conditioning plants. One example will be suggestive. A city hospital now under construction with 2,500,000 cubic feet has an elaborate ventilating system designed for future air conditioning. There will be a central plant with duct distribution for cooling the three lower floors and individual room units for the

[2]Comparison of Operating Results for 1952 in 53 Hospitals in New York, New Jersey, Connecticut, Pennsylvania and Maryland, Greenman, MacNicol & Co., hospital auditors, New York City.

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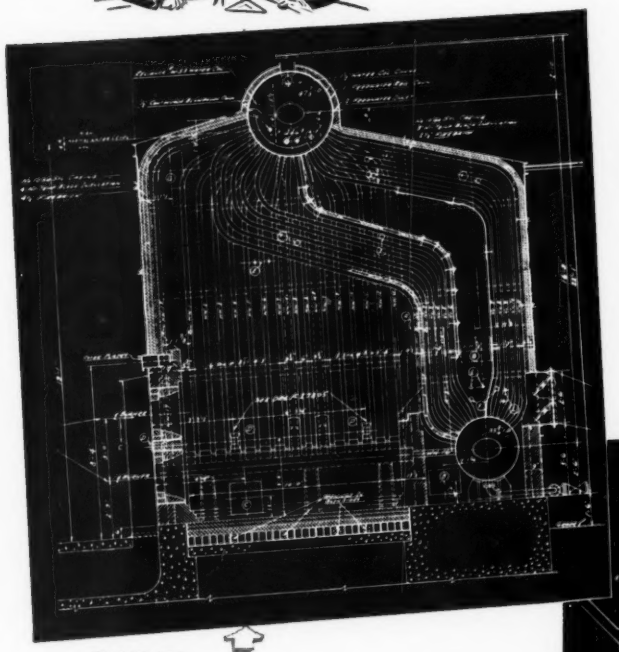
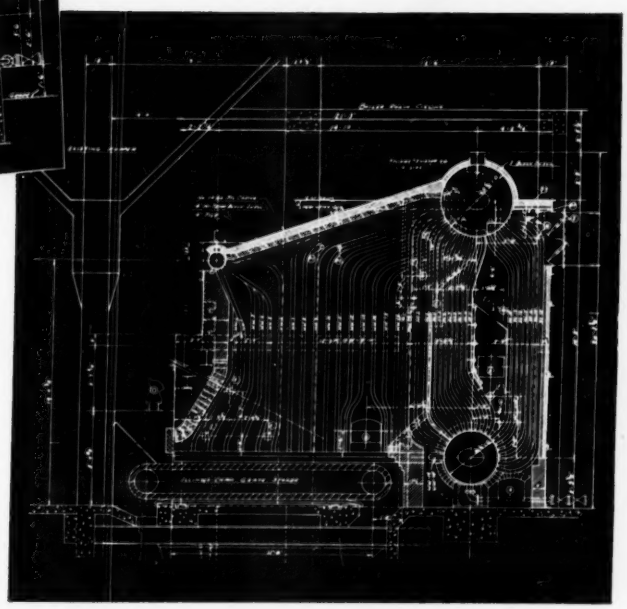
by Vogt



CLASS VF
A 22,000 pounds steam per hour unit installed at Indiana Farm Bureau Refinery, Mt. Vernon, Ind.



CLASS VS
The Seelbach Hotel, Louisville, Ky. is served by this 30,000 pounds steam per hour boiler.

A wide variety of industrial plants and other users of steam for power, processing, or heating have found these efficient Vogt Two-Drum Type Boilers to be the answer to their diverse steam generating requirements.

Class VF units provide maximum capacity in limited floor space and head room, while Class VS is best adapted to installations not having such restrictions. Each has a large furnace volume and a high ratio of radiant heating surface. The furnace design assures proper combustion of fuels fired in suspension or with various type of stokers.

A bulletin with general information and showing typical installations is available on request.

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upper floors. The engineers specify 14 supply and 23 exhaust fans with a total of 140 motor h.p. About 40 per cent of the supply is designed for the addition of cooling when funds are available. Until that time it will function as a straight ventilating system. The design has been somewhat influenced by the city code, but by and large it seems to hark back to the old discredited plenum systems.

In comparison, a conservatively engineered suburban hospital built in 1950 has a bulk of 2,400,000 cubic feet in a compact structure. It has hot water heat and exhaust ventilation only. It has six exhaust fans aggregating 14 h.p., which are run as needed — and it works.

Hospitals, no matter what the cost, must continually add to their professional resources in new equipment and technics that will contribute to better diagnosis or more effective treatment of the patient. But does air conditioning qualify from this standpoint?

Some 13 years ago at the request of THE MODERN HOSPITAL, I explored the value of air conditioning to the hospital patient.[3] What can it do for the sick?

A review of a hundred or so articles that had appeared in scientific publications in the previous five years disclosed no factual evidence of its therapeutic value for a hospital patient and in this respect there is no change. Comfort is the only advantage except that, as my survey showed, in operating and delivery rooms and in recovery wards air conditioning contributes to the efficiency of the surgeon and to the recovery of the patient in the postoperative stages. I cited two carefully controlled studies of life insurance companies of the value of year-round air conditioning for several thousand employes. These showed no significant difference in matters of health, absenteeism and other pertinent factors between employes working in air conditioned quarters and those in rooms properly ventilated.

I have had considerable experience as a hospital patient; one siege of 14 weeks in a plaster cast, overlapping into the summer months, and another of four weeks in a south room during a very hot August. I studied objectively whether air conditioning would have helped me. There were no periods of discomfort from heat which a room fan did not overcome adequately.

Thus it would seem that, if the patients are not directly benefited, the hospital must consider any investment in general air conditioning solely from the standpoint of comfort and increased efficiency on the part of its staff.[4] Can hospitals afford to do this, and what will it do to the mechanical budget? Add how much to what?

The present spread in hospital power, light and heat costs is fantastic. Greenman, MacNicol and Co. have assembled the 1952 operating figures for 53 hospitals for which they are auditors. In the group of 18 large institutions ranging from 281 to 635 beds the average annual cost per bed for power, light and heat was $289 but with a spread of from $172 to $463. These 18 hospitals had a combined operating deficit of $4,687,020, *excluding depreciation.* From our own data several hospitals with new additions that were fully insulated, with new heating plants and with only the necessary exhaust ventilation, spent from *$74 to $97 a bed per year* for the entire plant, new and old.

An entirely new hospital, properly designed and insulated, with a mechanical plant that incorporates the most effective type of heating and simple exhaust ventilation should not have to spend more than $70 per bed per year. In a hospital so designed, perhaps a simplified cooling system with conservative ventilation might be an economic possibility. To develop what the hospital might afford will call for the closest cooperation, imagination and vision on the part of the architect, the hospital consultant, the consulting engineer who designs the plant, and the air conditioning manufacturer who furnishes the equipment.

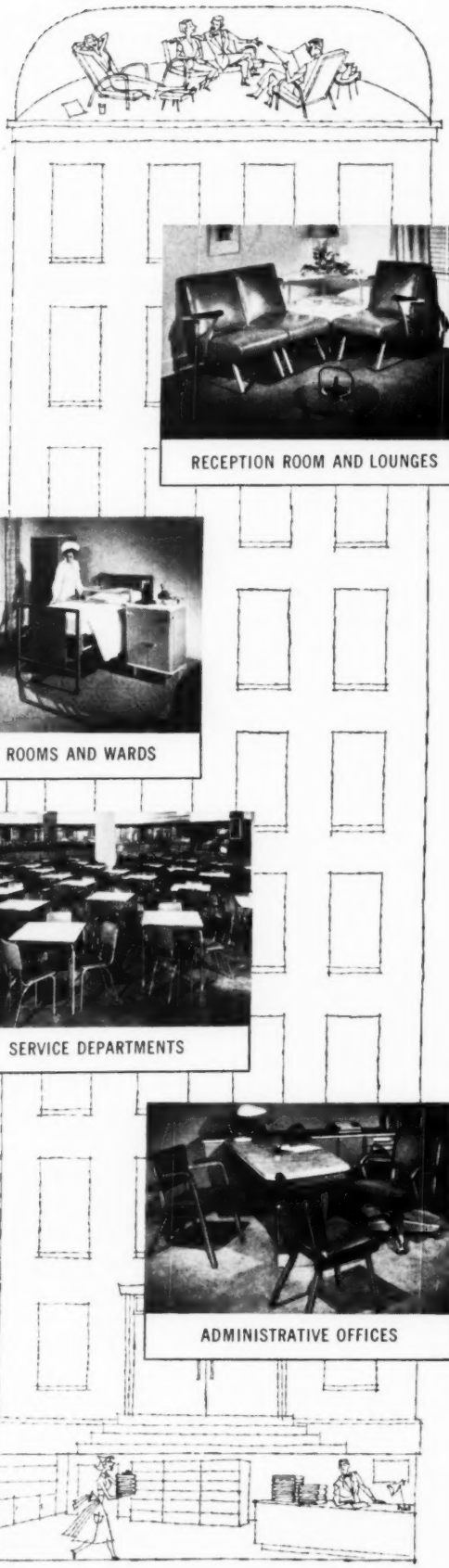
APPRAISING THE NEED

What is the extent and what are the extremes of summer temperature which year-round air conditioning is primarily designed to control?

(*Continued on Page* 128)

[3]Neergaard, C. F.: A Trustee Considers Air Conditioning. Mod. Hosp. **53**:60 (July) 1939. Also Refrigerating Engineering, November 1940.

[4]Those who would explore the physical and physiologic principles and elements of air conditioning in relation to people, comfort and atmosphere will find a wealth of scientific data in publications of L. P. Herrington, director of the John B. Pierce Foundation Laboratory of Hygiene at Yale and C. P. Yaglow of the Harvard School of Public Health. Their studies deal analytically with the conditions with which the engineer must deal mechanically—the atmosphere around the earth, temperature, humidity, pollution, odors, volatile organic matter, air borne infections, drafts.



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In New York's winters there are some 5000 hours when heating is required. Air conditioning engineers estimate that summer cooling is needed from 800 to 1000 hours in office buildings and up to 1500 hours in restaurants and theaters. In the hospital, no one knows!

For the average person 85° F. probably represents the threshold of oppressive summer heat. How often does it occur and how long does it continue?

The Summer Weather Data Book gives for New York City the summer degree hours above 85° as a probable maximum of 570 with a probable average of 375. The Weather Bureau's data for its Central Park Observatory in New York City show for the 122 days in June, July, August and September in 1952 that there were nine days with an average temperature above 85° and 23 days with a maximum of 90° or higher. For 1953, when the parboiling heat wave broke records in scores of cities for successive daily temperatures in the nineties (the average was 10 days), the New York City record for the four months was nine days with an average temperature above 85° and 31 days with a maximum of 90° or over.

"It's not the heat but the humidity that hurts." Newspapers in reporting extreme weather conditions — "Temperature Reaches 98°, Humidity 90%" — invariably neglect to say that 98° F. temperature occurred at 3 p.m. and the 90 per cent humidity at 7 a.m. For July 1953, which had the high record of hot days, the relative humidity tables show averages for the month of 71 per cent at 7 a.m., 49 per cent at noon, 56 per cent at 7 p.m., and 69 per cent at midnight.

In equipment design more emphasis is now being directed at humidity control by recirculation. This avoids excessive chilling of the air to remove moisture and then reheating it to the comfort level. It should overcome the commonest fault of air conditioning, making the room too chilly.

Anyhow, most people when they want to know how hot they are look at the thermometer; they have no humidistat.

TYPES OF EQUIPMENT

There are several different types of air conditioning, varying in principle and equipment, in space and ceiling heights required. Before a hospital is planned the major types should be

carefully reviewed so that the most appropriate may be selected. At this time, before the engineering plans are drawn, the consulting engineer and manufacturer should prepare an approximate budget for cubage, equipment and installation and project the probable annual cost of operation and maintenance.

1. The most effective but probably not the most economical is the peripheral system. This system circulates hot or cold water through coils in units located on the outside wall and also passes filtered humidified or dehumidified air over them from a central plant. A pan underneath the coils connected with the drainage system carries off the condensate. While manual control is possible, automatic control is most appropriate. With this system it is necessary to clean the coils and pans frequently as dust from the recirculated air and slime from the condensate accumulate and give off objectionable odors.

2. A separate heating plant with radiators and a duct system that distributes from a central plant cooled and conditioned air, humidified or dehumidified, throughout the building. This is less expensive in first cost but is less effective. The draft problem is difficult.

3. The high velocity dual duct system which brings hot and cold conditioned air to distribution units. Where walls are insulated and windows are double glazed, these units can be located in the ceilings or the inside wall, the least expensive installation. If windows are single glazed the distributing units should be on the outside wall, if in low temperature areas. In any case heating pipes, coils and radiators are eliminated, and the system has the added advantage of being noiseless and draftless with much simpler controls.

4. The compressor package unit of from 3 to 15 tons' capacity, which will cool from 300 to 400 square feet of floor space per ton.

5. The individual self-contained room cooler of which there are many makes, which is inappropriate for the patient's room because of noise and drafts.

There is little actual *hospital* experience to determine which of these types is the most practical.

WHAT IS INSTALLATION COST?

How much will the hospital have to spend for year-round air conditioning that adds summer cooling, general ventilation, humidity control, and filtered air to the heating it has always had? Consulting engineers and air conditioning manufacturers use, for budget purposes, cost figures of from $700 to $900 a ton of refrigeration, which includes the distributing system, control, pipes and ducts, with $120 to $150 a ton additional for heating equipment, or a total of from $820 to $1050 a ton. A ton will take care of from 300 to 400 square feet of floor space.

Thus, year-round air conditioning would cost from $2 to $3 a square foot. To arrive at a comparable figure for heating and simple exhaust ventilation is somewhat complicated. How much heating is needed per square foot? C. E. Daniel, formerly consulting engineer of the Hospital Facilities Division of the U.S. Public Health Service, has evolved a simple formula based on wide hospital experience for estimating radiation: "In a completely insulated, double glazed building for 0° design temperature, 1 square foot of radiation will heat 160 cubic feet of space; without insulation and double glazing the ratio would be 1 square foot to 80 cubic feet."[5]

In a hospital 160 cubic feet would represent approximately 15 square feet of floor space.

Several building contractors quote from $6 to $8 a square foot of radiation as the figures used in estimating the cost of a complete heating plant. Thus if 1 square foot of radiation will heat 15 square feet of floor area, the heating plant cost will approximate 40c or 50c per square foot as compared to $2 to $3 for complete air conditioning.

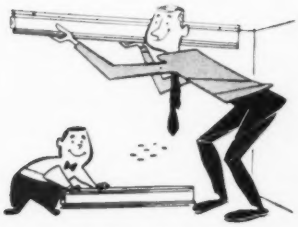
The exhaust ventilation varies so widely that no unit cost figure is obtainable but it would be only a few pennies more.

WHAT WILL IT COST TO RUN?

Another involved computation is necessary to relate the hospital auditors' inclusive annual cost per bed for power, light and heat to the engineer's unit cost per square foot for heating and ventilating.

Greenman, MacNicol's operating figgures for 18 hospitals, excluding depreciation, show an average annual expenditure for power, light and heat of $289 per bed with a spread of from $172 to $463. A breakdown of the various items—labor, fuel, water, electricity and miscellaneous—justifies the

[5]Daniel, C. E.: Functional Engineering, Mod. Hosp. 75:120 (September) 1950.



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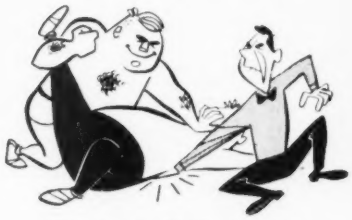
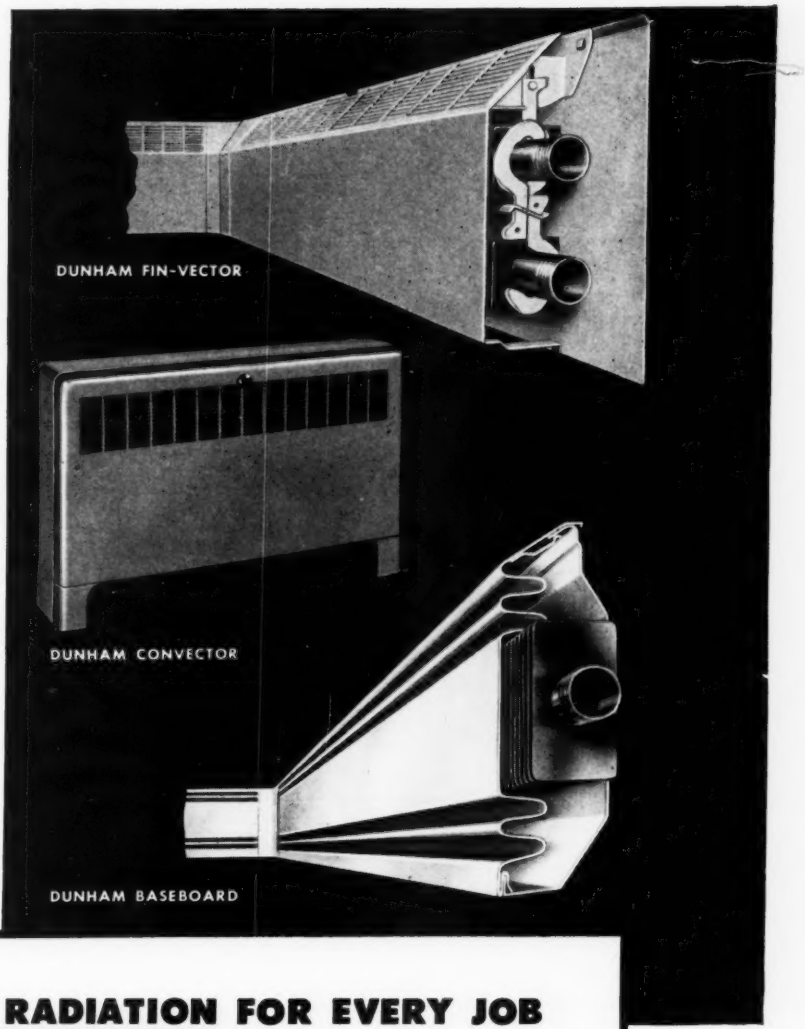


"Fits flush with the floor—no 'cleaning under' problem"



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estimate that 50 per cent of the total is for heating and ventilating and 50 per cent for year-round services — domestic hot water; steam for laundry, kitchen and sterilizers; lighting and electric power.

The area requirements of a large general hospital, according to U.S. Public Health Service tables, is upward of 500 square feet per bed exclusive of outpatient department and housing. On this basis the average of $289 per bed would represent a cost of 28.9¢ per square foot for heating and ventilating and 28.9¢ for other services.

What these 18 old hospitals spent on an average in operating their present plants is little indication of what the operating costs would be in a new hospital, thoroughly insulated, well designed, with an efficient power plant and conservatively engineered heating and ventilating systems. In our experience with such buildings the power, light and heat costs have not exceeded $100 a bed including year-round services and the heating and ventilating, the latter less than half the total, or from 6¢ to 8¢ a square foot.[6] This compares with 28.9¢ in the 18 old buildings. Here is a substantial potential saving that might go far toward meeting the running cost of air conditioning, if there is money enough to install it. But what will it cost to run?

While the large capital investment in air conditioning is a serious matter, the hospital's most vital concern is its effect on the operating budget for years to come. The fact that in 1952 the expenses of our 3000 voluntary hospitals exceeded what they received from patients' care by $140,000,000 indicates the urgency of keeping basic maintenance at a minimum.

It has not been possible as yet to obtain operating figures from the score or more air conditioned hospitals in the South and West, and no definite figures are available from the experience of the new hotels and office buildings to indicate how much expense summer cooling adds to winter heating. Engineers of the Carrier Corporation have projected the summer and winter costs for owning and operating the latest and most complete air conditioning system in a de luxe New York City office building completed in 1951. Allowing 20 year amortization on the equipment, the owning and operating expenses reduced to a square foot basis total 70.3¢ per year, of which 22.3¢ is for operating and 48¢ for owning—for amortization, insurance, interest and taxes. This is an essential cost figure too frequently omitted from hospital accounting.

They further broke down the operating cost: for the five summer months, cooling, ventilating and exhaust, 10½¢ per square foot; for the seven winter months, heating, ventilating and exhaust, 11.8¢, or a total of 22.3¢. They estimated the annual cost for conventional heating by direct radiation at 6¢ a square foot a year, to which would be added approximately 1¢ for exhaust ventilation of toilets and the like. This is in close agreement with our figure of 6¢ to 8¢ a square foot for the same services in an insulated hospital.

Thus the annual cost of operating a complete air conditioning system is three times that of a heating system.

Alfred L. Jaros of Jaros, Baum and Bolles, in a paper presented in January 1953 before the New York Real Estate Board, gave the total cost of air conditioning, based on comprehensive data: A 1000 ton plant in an office building with 300,000 square feet of

[6] Neergaard, C. F.: Cutting Hospital Costs. Heating, Piping and Air Conditioning, November 1953.

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rentable area, steam driven compressor, steam and current purchased would increase the cost by $1,600,000,or $5.35 a square foot. This includes mechanical plant, electric power service and other such accessory work. The annual operating cost, including steam at $1.18/M lbs., electricity at 3¢ per kwh., all labor and maintenance, would be 36¢ a square foot. The annual fixed charges, including 4 per cent interest, 4 per cent depreciation, and 3 per cent taxes, would amount to 58¢ a square foot, or a total of 94¢ a square foot.

These various estimates for installation and operation seem to indicate that some simpler form of plant than the elaborate installations in office buildings is needed for hospitals, to provide a measure of comfort short of the ideal.

The hospital will advisably approach the problem critically and obtain from the engineer and manufacturer a projection of all costs and assurance of continuing service.

A maintenance contract of the type now offered by one manufacturer, for example, will be almost a prerequisite for any hospital. For a fixed, predetermined amount annually it covers supervision, routine inspection, emergency service, adjustment, repairs and refrigerant supply for the life of the plant. Furthermore this corporation will make an accurate forecast of the fuel, electricity and water cost for each ensuing year. Thus the hospital's engineering staff would be relieved of the complicated maintenance of the air conditioning plant, and the over-all operating cost of air conditioning would be known in advance.

Our experience with the comfort and operating economy of panel heating in several hospitals suggests that panel cooling as successfully used in England, Switzerland and Canada might be adopted to provide summer comfort levels, given effective control of the dew point. Panel heating in England saves upward of 30 per cent in fuel over radiation and it should save in cooling costs. Where installed in hung ceilings the cost will run from 20 to 30 per cent more than radiator heating. Panel heating ceiling coils in a thin slab floor have been installed in two of our hospitals, in one instance at 10 per cent less than an actual bid for radiators. The Long Island Jewish Hospital, to be completed in 1954, with the double corridor plan, is the first hospital in the country as far as is known to adopt combined panel heating and panel cooling. It uses 55° F. well water and no mechanical refrigeration. Condensation is controlled by exhaust ventilation.

Structural economy is significant. E. Lorne Wiggs, C.E., a proponent of panel heating and cooling who has engineered many air conditioned buildings in Canada, estimates that whereas in the conventional air conditioned building with ducts some 19 per cent of the total cube is required, with panel heating and panel cooling only 6 per cent to 7 per cent is needed.

Perfection in plant design and precision in its control are the essentials of satisfactory air conditioning, but they are costly and complex. At a recent meeting of the American Institute of Electrical Engineers speakers criticized modern machines and electronic apparatus as becoming too complicated for the human mind to comprehend. "Either men or machines will have to be redesigned, and as men can't, machines must." Until such redesign has reduced the cost of year-round air conditioning to a practicable point, hospitals will be well advised to move cautiously in considering its use.

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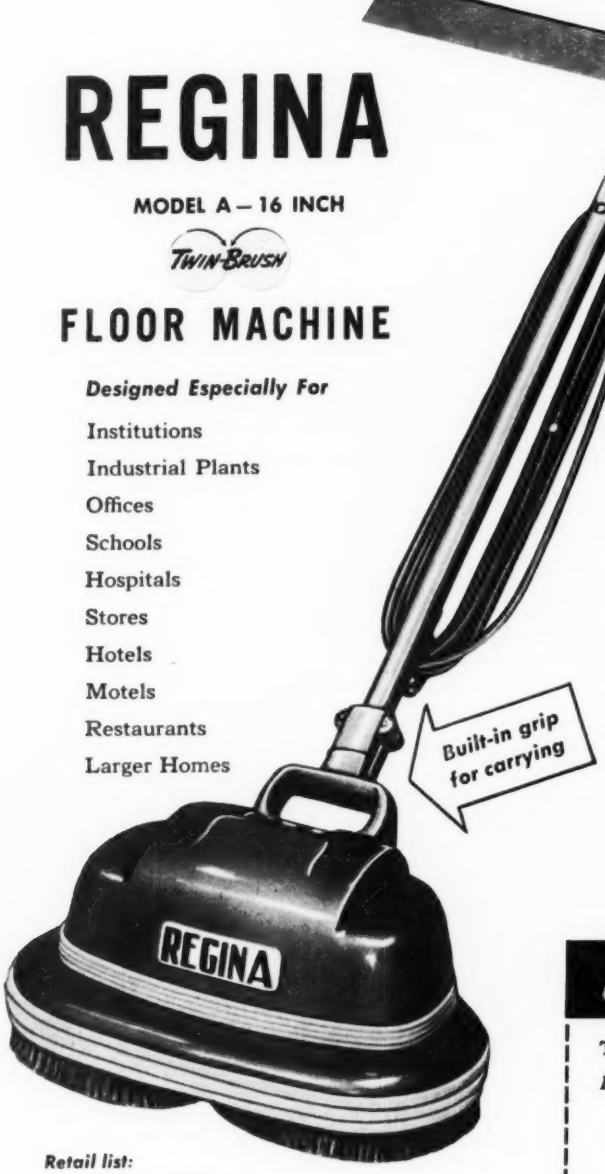

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TRAINING MANUAL ON WAXING—VI

FOUR Housekeeping Training Guides, covering sweeping, mopping, dusting and waxing, have been developed by the Veterans Administration for use in its hospitals. In this issue The MODERN HOSPITAL presents the concluding section of the manual on waxing. The manuals on sweeping, mopping and dusting have been presented in successive months, beginning in the January 1953 issue of this magazine.

Copies of the Training Guides have now been printed and are available to readers who are interested in obtaining them. Requests should be forwarded to the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. Cost of each of the Training Guides is as follows:

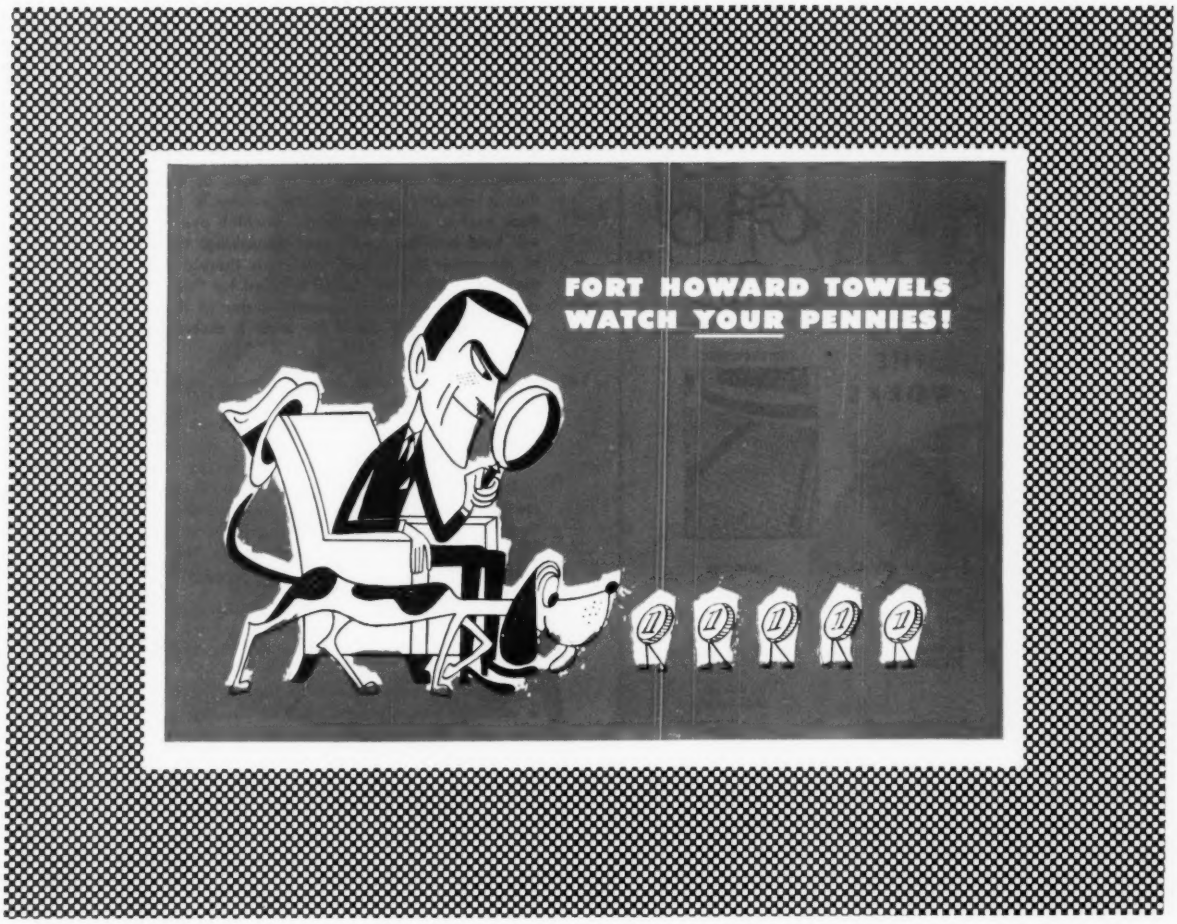
TG10-2 Sweepy, 25 cents each.
TG10-3 Moppy, 30 cents each.
TG10-4 Dusty, 20 cents each.
TG10-6 Waxey, 30 cents each.

A discount of 25 per cent is allowed for purchase in lots of 100 or more of any one Training Guide.

144. It is not always necessary to strip down a floor and completely remove the wax coat. It would not be either economically or physically possible to resort to giving the floor "the works" each time it required cleaning. So there must be a modified method of cleaning performed in the interim periods.

The frequency with which this modified method may be used will be dictated by the existent condition of the present protective wax film and the amount of traffic on this floor. If the floor is adequately filmed and/or if the traffic is light in this area, the dry cleaning method may be used as often as is necessary. It should not be used, however, once the wax film becomes too thin to act as a protective coating. Once the wax film becomes too thin to act as a protective film for the floor, the flooring should be given "the works," which will again provide a protective film.

Conversely, this dry cleaning method should not be used on floorings that may still have an adequate coating which may have become yellow with age. The very



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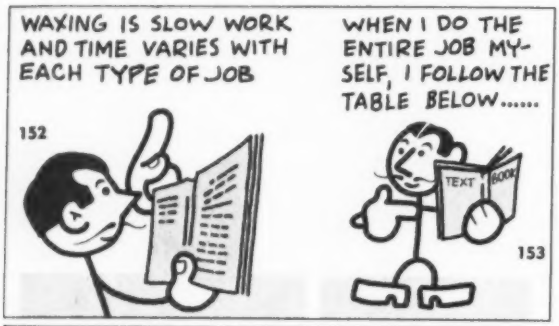
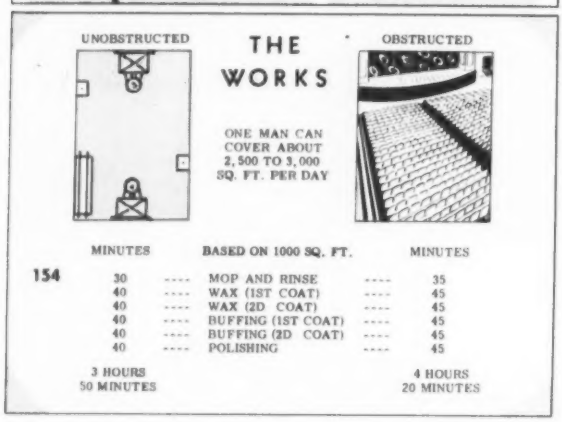
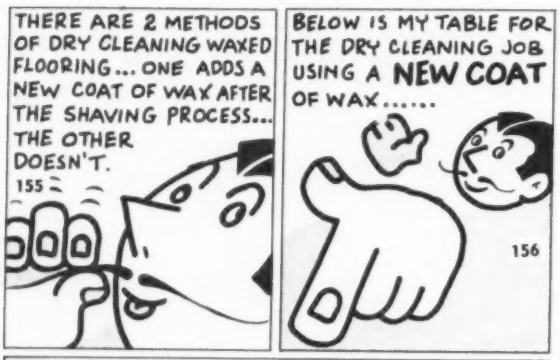
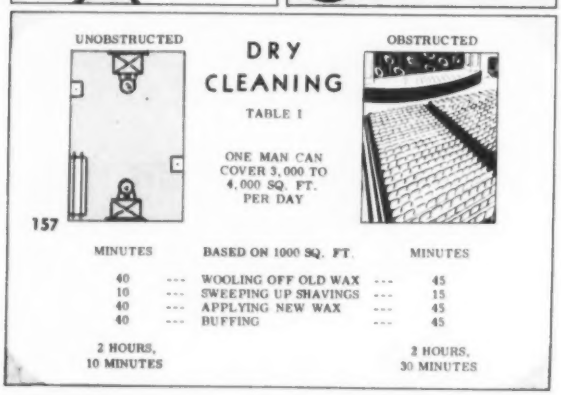








old wax film, which has dehydrated into an amber hued, pocked appearing surface, will not respond to the dry cleaning method. It is then too far gone to be adaptable to the use of this short cut.

145. In the dry cleaning procedure the wet mopping operations can be completely eliminated. The only time they might possibly be required is when a spotting-in job may be needed in some part of the area. The elimination of the washing operations will, of course, lessen the time required.

146. To attach the steel wooler to the rotary machine, it is not necessary to detach any of the parts of the machine. All that is required to attach the wooler is to lay it on the floor and to place the rotary machine over it. This wooler will hold best to the coarser (scrubbing) brush than it will to the softer (buffing) brush. It is therefore recommended that only the coarser brush be used for this. Too, inasmuch as the buffing brush is considered one of the "clean" tools, it is better not to use it for what is essentially a cleaning operation.

147. Waxey has concisely stated what he does in this operation.

1. With the steel wooler he shaves off an infinitesimally thin coat of damaged top layer wax.
2. He disposes of the impounded soil within the wax.

The vital points in the instruction in this step of dry cleaning operations are: that only a hairline thickness of the wax is to be removed; that ample wax must be allowed to remain on the floor to protect it. The old wax must literally be just "shaved" off.

148. The thin shavings of old wax and the tiny broken particles of steel wool which result from this operation must now be removed from the floor before the next operation is begun.

Naturally, the best way to remove them from the floor is with a vacuum machine. If a vacuum is not available, the next best sweeping method is followed. Whichever sweeping device is used, it is of vital importance that every particle of the fragments of the steel wool be removed before they can cause anyone harm.

149. In order to provide the resilient flooring with an ample film of protective wax, Waxey must now replace the thin dirty layer which he has just shaved off the floor. So, he again cuts in the edges with his block applicator, then thinly recoats with wax the larger center portion of the area, gets the floor good and dry, and then proceeds to the next operation.

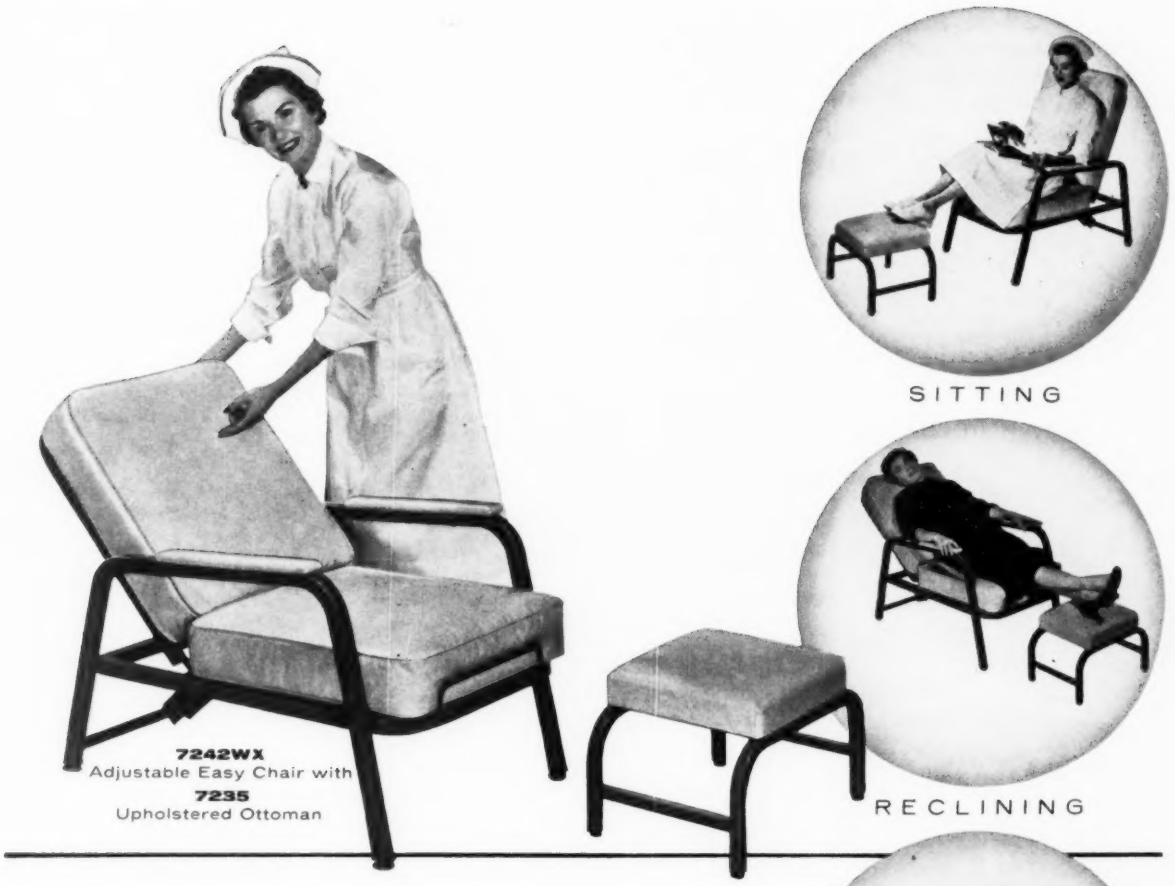
150. Wax bubbles or blisters can happen to any type of application. They must be removed before the final polishing processes. If the waxer is unlucky enough to have caused bubbles during his wax applications, there is no alternative but to remove them, as Waxey described earlier in this manual.

151. As in every other waxing operation, the final steps of buffing and polishing must be done.

152. It is hard to establish the exact amount of time that each waxing job will require. There are so many factors to consider.

For instance, there may be considerable spotting to do, or the weather may be humid. There may be very stubborn old wax to remove; there may be more than an average number of gum-wads to remove; distances from one job to another may be greater; equipment condition, too, can alter the amount of time for stripping or application or polishing. In addition to all of these things, there must be included excessive traffic conditions, which cause the waxer to stop frequently and thereby increase the length of time which it takes to complete the waxing and polishing operations. The number of obstacles which must be first moved out of the way, the wait for dry and polish time, and the return of these obstacles so that the next small patch of flooring can be serviced are extremely time consuming. Each one of these extraneous items must be given consideration when computing the amount of time that must be allowed for each waxing job; no two jobs are alike.

(Continued on Page 140)



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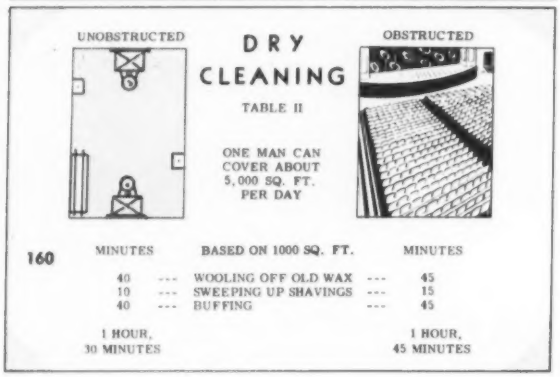

153. Whether one man has to do the entire waxing operation or whether he has two or more workers assisting will also have a bearing on the time required to complete a waxing job. If Sweepy would first perform the sweeping operations, Moppy, the mopping operations, and if Waxey need only apply wax film and then do the polishing operations, the waxing job could be completed in a much shorter time.

If there is no team and a single worker has to keep changing tools and equipment and has to wait for drying time, his progress will be much slower. Proficiency, too, enters into this. The man who is highly proficient at one or two of these three major operations may not be proficient in all of them. A man who might be a very skilled waxer and polisher may be a very poor mopper. So the timing and the results must be gauged by the skill and aptitude of the individual worker.

Waxey, who has a reasonable amount of skill in all steps of the waxing operation, can perform the entire operation in the following lengths of time.

154. Waxey has previously described three different types of floor waxing methods. The coverage tables will be different for each of the three methods.

They will have only these two similarities:

1. They are all based upon a unit of 1000 square feet.
2. They will all show the difference between the time required to perform the same number of functions in two distinctly different areas, namely the *unobstructed area* and the *obstructed area*.

Waxey will first describe how long it should require to perform the six operations in the method called "The Works."

These six operations are:

1. Mop and rinse
2. Wax (first coat)
3. Buff (first coat)
4. Wax (second coat)
5. Buff (second coat)
6. Polish

In the *unobstructed* column you will see the average lengths of time required to perform each of these steps. These figures show that it should take—per 1000 square feet—

30 minutes to mop and rinse
40 minutes to wax (first coat)
40 minutes to wax (second coat)
40 minutes to buff (first coat)
40 minutes to buff (second coat)
40 minutes for polishing

The waxing time, first and second coats, is inclusive of the time required for drying.

Therefore, for each 1000 square feet of unobstructed floor area to receive the full waxing treatment, the average waxer should plan on 3 hours and 50 minutes.

On the far side (right) of this diagram Waxey shows the lengths of time which will be required for the same operations in an *obstructed* area. This is a much slower operation, for there are many obstacles to a waxer's speed. Waxey modestly allows only an extra five minutes for each of the operations. Even with this modest estimate, there is an over-all increase of 30 minutes required to wax a like amount of space. Here his total amount of time required to mop and rinse, wax (two coats), buff (after each coat), and polish requires 4 hours and 20 minutes for each 1000 square feet of floor area. This is indeed making haste slowly.

All in all, Waxey estimates that a good waxer using good methods can cover approximately 2500 to 3000 square feet of floor area per day.

155. Waxey knows from his experience with the floor which of the two dry cleaning methods he may use. He has previously told how to determine which of the two methods to use. Now he will tell the length of time required to use each of the methods.

156. This "one coat" method of adding one more thin coating of wax film to the existing film on the floor may be used

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only when the existing wax film is of adequate density to serve as a protective coating for the resilient floor.

As you will note, Waxey uses only four operations in this method, which is outlined in Table 1. The fact that he uses fewer operations has a bearing on the lessened time that will be required for this method.

157. TABLE 1:
Here again Waxey uses 1000 square feet as a basis of measurement.

The four operations that he utilizes in this method are:

1. Wooling off old wax
2. Sweeping up shavings
3. Applying new wax
4. Buffing

Here, again, Waxey differentiates between the operating speed in the unobstructed areas as compared to that required in the obstructed areas.

It will be noted that in the *unobstructed areas*, he states, that it should require the following time for each operation:

Wooling off old wax	40 minutes
Sweeping up shavings	10 minutes
Applying new wax	40 minutes (inclusive of drying time)
Buffing	40 minutes
Total time required . . .	2 hours and 10 minutes

On the *obstructed areas* he again allows an extra five minutes for each of the operations. He thus states that the timing in the obstructed areas should be as follows:

Wooling off old wax	45 minutes
Sweeping up shavings	15 minutes
Applying new wax	45 minutes (inclusive of drying time)
Buffing	45 minutes
Total time required . . .	2 hours and 30 minutes

Insofar as timing is concerned, this method has a distinct advantage over the length of time it requires to use "the works" method.

Waxey's studies indicate that by using the method shown in this table, a good waxer should be able to service approximately 3000 to 4000 square feet in a work day. The variation of time will depend largely upon his skill and upon the conditions existent.

158. Before Waxey can safely determine the advisability of using the method shown in the following table he must be sure that there is an adequate wax film still on the floor.

159. This method can be used only a time or two after the flooring has had complete servicing. It is unsafe to use on a poorly waxed flooring. It should not be used if it will in any way jeopardize the life of the natural plating of the floor.

160. TABLE 2:
This table again depicts both the unobstructed and the obstructed areas. It differs, however, in the number of waxing operations required in this simple method.

There are only three operations:

1. Wooling off old wax
2. Sweeping up shavings
3. Buffing

The time required for each of these operations is, again, in unobstructed areas:

Wooling off old wax	40 minutes
Sweeping up shavings	10 minutes
Buffing	40 minutes
Total for unobstructed area	1 hour and 30 minutes

Again Waxey allows an extra five minutes per operation for the obstructed areas, which brings the total time required for obstructed areas up to 1 hour and 45 minutes. If and when it is advisable to use this method, a good waxer, should be able to service approximately 5000 square feet of flooring per work day. This method is the fastest of all and permits of a very large coverage in a work day.

161. Waxey has demonstrated that there are many operations and many required skills associated with floor-care procedures. Adequate knowledge and training are extremely important in the development of these skills.

162. The floor is Waxey's palette. He gives it the same sort of tender, loving care, that any artist would give his work. His intense interest in his job has given him such enthusiasm that it has resulted in the title which he has so justly earned—that of waxing artist!

163. Even in the creation of art, there must be some labor. Hard work seems insignificant when the results of one's labors are appreciated by as many people as Waxey serves in the V.A. hospital.

He has a hand in setting the stage in which the professional staff functions and which helps to effect better patient care.

He has a hand in improving the appearance of the hospital so that all the hospital employes can be happier in their work.

He has the rare privilege of working for the patients and of providing such an inviting appearance in the hospital wards that it has a therapeutic effect upon them.

164. Inner satisfaction is the greatest reward that any workman can derive from his work. Psychologically, this inner satisfaction is often of more value to the worker than is the remuneration he receives for his labors.

There is no other branch of housekeeping service which will bring as many comments of approbation as will beautifully cared for floorings. They give satisfaction to everyone and especially to the waxer who has produced them. The wise instructor will capitalize on this and will make the most of every opportunity to create in the waxing trainee the idea that waxing hospital floors is an important art.

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Standardization as a Tool for Better Care

(*Continued From Page 78*)

given period, *i.e.* daily, weekly or monthly.

4. Determine emergency requirements.

5. Establish items and quantities to be kept on the unit and those to be obtained from elsewhere as needed.

6. Decide where on the unit they will be kept — linen closet, utility room, medicine chest, or patient's room.

7. Work out an orderly arrangement for storage areas, putting articles most frequently used in the most accessible place.

8. Make a chart showing the individual items, their location and quantity for each storage area, and post it in a conspicuous place.

9. Make a definite assignment for the care of the storage areas, including the daily cleaning, inventorying, and stocking.

10. Impress on all personnel the value of the familiar quotation: "A place for everything and everything in its place."

11. Set up one nursing unit as a demonstration area.

12. Evaluate standards and make changes when necessary.

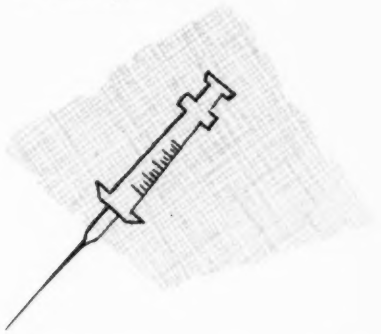
When all units are arranged according to a standard pattern, the assignment and rotation of personnel are accomplished with minimum confusion and frustration.

When a new building is planned or an old one is remodeled, some standardization of units is desirable to promote flexibility and increase efficiency. For instance, when all operating rooms are the same size and are provided with a standard amount of basic equipment, ease in utilization for different types of surgical operations results.

Hospital standardization has its place and uses. Use it as a tool but do not allow it to become a "master." It must never be static or administered in a rigid dogmatic way. Constant and frequent review, study and changes are necessary. Anyone who has worked in a hospital where standardization has been intelligently planned and maintained will vouch for its value as a tool for greater efficiency and better patient care.

THE GREEN LINE

EST. 1874



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2. MEDICATION PERIOD REDUCED MORE THAN 50%.

3. MINIMIZES POSSIBILITY OF ERRORS IN ADMINISTRATION OF MEDICATION — PROVIDES SECURITY FOR PATIENTS.

4. REDUCES BREAKAGE OF SYRINGES AND SPILLAGE OF MEDICINES AN ORDERLY ARRANGEMENT OF MEDICATION IN ITS PROPER PLACE.

5. UNNECESSARY BACK AND FORTH TRIPS TO THE NURSES STATION REDUCED.

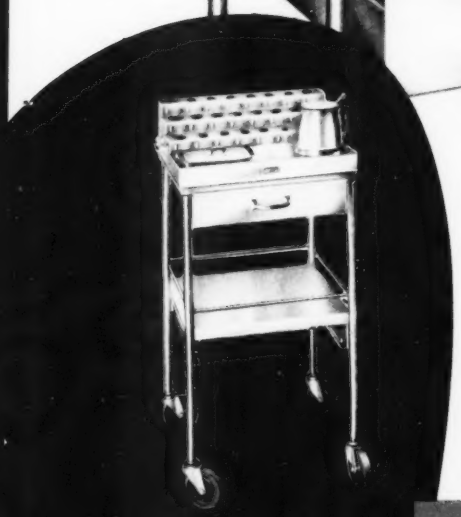
6. COORDINATION OF ADMINISTERING PERSONNEL MORE READILY ACCOMPLISHED.

7. MORE TIME IS MADE AVAILABLE FOR OTHER NURSING DUTIES.

8. REMOVABLE TOP — BY REMOVING TOP TRAY A 16" x 20" MOBILE UTILITY TABLE IS AVAILABLE FOR OTHER USES.

9. A COMPACT UNIT OF ALL WELDED STAINLESS STEEL CONSTRUCTION — EASILY CLEANED.

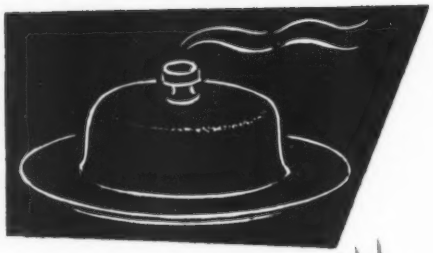
10. REDUCTION OF BREAKAGE, TIME AND PERSONNEL ENABLES MC-01 TO PAY FOR ITSELF IN A SHORT TIME.



MC-01

THE MC-01 IS A REVELATION TO HEAD NURSES IN THESE DAYS OF NURSING SHORTAGE, LACK OF HELP AND GENERAL OVERCROWDING OF OUR HOSPITALS. NEW PATIENTS FEEL MORE SECURE WHEN NEW TIME SAVING EQUIPMENT IS UTILIZED WITHIN THE INSTITUTION. THE NEW PATIENT FEELS MORE AT EASE TO KNOW THAT THIS NEW EQUIPMENT DOES NOT LEAVE HIM AT THE MERCY OF OVERSIGHTS AND ERRORS DUE TO TOO MUCH WORK FOR TOO FEW. IT ENHANCES EFFICIENCY BY ITS APPLICATION. CARE IN PREPARATION AND ADMINISTERING IS UNDER CONTROL AT ALL TIMES. THE MC-01 IS TIME, LABOR AND MATERIAL SAVING FOR THE HOSPITAL; AND PROVIDES SECURITY FOR THE PATIENT.

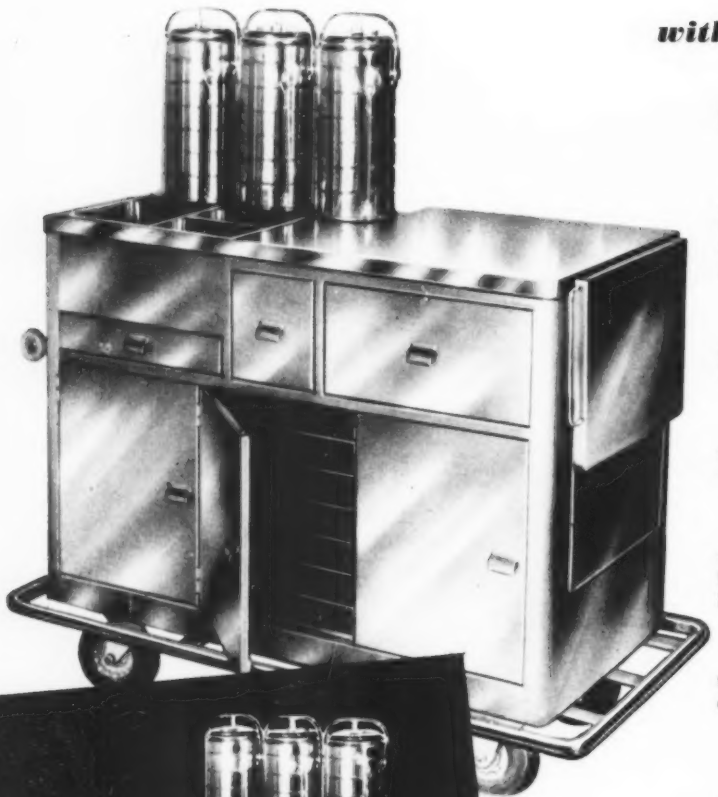
Robert M. Green & Sons, Inc., Nesquehoning, Penna.



THE GREEN LINE

EST 1874

Hot or Cold Food Now Assured with Newport Food Conveyor



CENTRALIZED KITCHEN CONTROL

1. Meats and vegetables are served under supervision of the dietitian and placed in a pre-heated or pre-cooled compartment and kept at the proper temperatures assuring patient of a piping hot or crispy cold meal.

2. Preparation is made well ahead of mealtime thereby releasing very valuable help for peak load operation.

3. The Newport cart now serves as storage space and conveyor of soiled dishes to dish washing section.

4. The Newport cart, being entirely of stainless steel, is easily cleaned and lends itself to spic and span orderly arrangement when not in use.

5. Thermo containers for coffee, milk, clear soup or water are all stainless and easily cleaned. These are supplied at additional cost.

6. Serves 36 complete meals.

Five plate compartments with individual thermo switch control, either compartment may be heated or refrigerated. Refrigeration by dry ice, cartridge or eutectic plate.

Steam table well with 16 qt. meat pan for extra helpings or selective diets. Opposite side (3 sections, either heated or refrigerated) for salads, desserts, etc.

SPECIFICATIONS FOR NEWPORT FOOD CONVEYOR

Overall Length 62" approximately
Overall Width 30" approximately
Overall Height 46 ¾" approximately, with 10" casters
Overall Height 43 ¾" approximately, with 8" casters
Shipping Weight 510 lbs.

Robert M. Green & Sons, Inc., Nesquehoning, Penna.

A Sound Program of Nursing Education

(*Continued From Page 77*)

make its influence felt throughout the community an understanding of sociology and community resources is necessary. Student nurses, graduate nurses, practical nurses and aides are important agents in a public relations program. Knowledge and skill in dealing with people do not come without effort and practice.

The better the physical facilities the more readily can a good educational program be carried out, but the best physical plant is worthless without a well qualified faculty. A good educational program can be carried out in a basic three-year diploma program. This is the program which is probably most familiar to us. As the need for education in the social sciences has been recognized, hospital schools have tended to turn to qualified nonnurse teachers to give instruction in these courses. These teachers have been found oftenest in junior or senior colleges or universities. Nonnurse teachers are often better qualified to teach the physical sciences than are nurses, so some hospital schools have tended to seek college or university affiliations and have left nurses free to teach nursing, which is obviously their special area. As students have taken courses from college instructors, in keeping with the trend in all fields to require some college education as a prerequisite to entering the field, arrangements have been made for student nurses to meet the requirement for college credits in the physical and social sciences. Affiliated three year diploma programs have been developed, and then stressing the academic side but recognizing the worthwhileness of nursing courses, there have been five year affiliated prorgams.

A natural outgrowth has been the establishment of some four year nursing programs in institutions operated expressly for educational purpose. Do not forget, however, that the educational institution must seek for its students clinical experience which can be found only in a hospital. We might easily spend the afternoon in a discussion of the variations that exist in the several types of programs which I have mentioned.

A school needs the best possible candidates for its program. Active recruitment programs must be undertaken. Students are upon graduation a potential source of personnel for all types of nursing service. Recruitment is no longer the project of the individual school. It is a community responsibility. Some hospitals which do not have schools of nursing participate in recruitment of students for other schools and even offer scholarship assistance. An effective technic of selection of students must be used. On a national average 30 per cent of the students entering schools of nursing withdraw. If this is roughly 10,000 per year, just think what it would mean to decrease the withdrawal rate both by more careful selection and by providing satisfying and stimulating academic and recreational activities for students in a school.

An active social program which provides group activities with fellow students and gentlemen friends takes a great deal of planning and care in execution. Students spending much of their time in the clinical area have a constant demand to "give" to others. During leisure hours it is necessary for students to find true re-creation. Many students gain refreshment from reading. Good school libraries should contain interesting books of fiction and nonfiction, as well as a variety of the required scientific references.

In present-day professional and vocational competition, a college degree has become an additional key to the doors of opportunity. There are programs in which a registered nurse can study for a college degree. Nurses motivated to do this are usually highly desirable members of a nursing service staff.

Nursing has become so dynamic and complicated that we no longer have learned enough when a prescribed program is finished. It is essential that there be a good staff education program in which nurses employed in hospitals may become oriented to new environments and continue to learn the new procedures in nursing which develop as there is progress in all the therapies. A great deal of education of the staff precedes a successful operation of the nursing team about which we have heard so much in the last few years.

A part of any team are the practical nurses and the nurse's aides. Good

Constant Attention

Constant attention is the essence of fine hospital service: in supplying every need of the patient . . . in watching every detail of maintenance and management . . . in demanding highest quality and greatest value when purchasing materials and equipment.

Constant attention must be given, for example, to the selection and maintenance of an adequate stock of sheets and pillow cases. That's why so many experienced hospital purchasing agents prefer UTICA Muslin sheets, woven with over 140 threads to the square inch (finished count). UTICA Muslins provide comfort and good appearance through long wear and many launderings.

UTICA Muslins are manufactured with constant attention to the most rigid standards of quality. They are made in one of the most modern mills of its kind in the world—to satisfy your standards of quality at the lowest possible cost to you.

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practical nurses are trained in a one or two year course under qualified teachers. Any administrator will find the care given by graduates of a correspondence school for practical nurses very expensive. I am happy to say that the approved practical nurse program in this city is a very fine one. It is a part of the Chicago public school system. Another member of the team is the nurse's aide. He or she is often trained on the job, with some classes and attentive supervision. The better the on-the-job training provided, the more economical will be the service return from the nurse's aide.

There must, of course, be provision for teachers, supervisors and administrators to learn to carry out their functions. To be sure, many nurses who have been successful in these areas have learned on the job, in the school of hard knocks, by experience. It may be a truism to say that experience is the best teacher. It should be added that it may be the most expensive one.

There are graduate programs in which opportunity is provided for nurse educators and administrators to study in their special field of interest and earn advanced degrees.

Nursing is regarded an indispensable service to society. The problems in nursing which have confronted the nation have shown us a need for research directed toward solving the problems. Nurses are most eager to participate in improving nursing education and nursing service. Extensive investigations must be undertaken to unravel the intricate web which has entangled nursing.

There is no clear agreement regarding the kinds of skills and understandings that are needed for successful performance in the various levels of nursing.

Established programs are quite rigidly bound by requirements of state law and there always seems to be a lag in putting into effect changes which may be deemed desirable and recommended.

Training in research technics can be obtained in some collegiate schools of nursing today.

There seems to be no end to the demand for nurses to participate in areas which are concerned with the promotion of health, the prevention of disease, and the care of individuals who have become ill.

We all need to cooperate to promote what is good and to eliminate what is bad in nursing education.

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Please send me the illustrated booklet "Which Floor Goes Where in Commercial Areas" which shows the advantages and disadvantages of various floor coverings and recommends where each type should be installed.

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MEDICAL RECORDS

(Continued From Page 84)

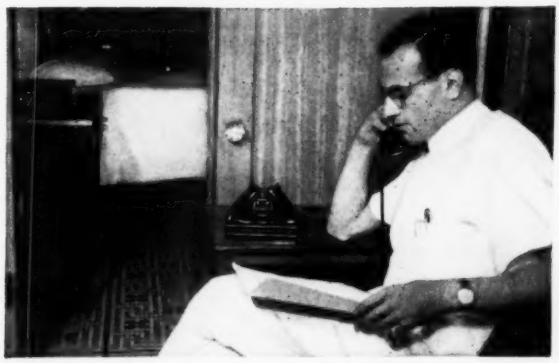
cording to the information on the cards. Such punching of new cards is much less time consuming than is punching a separate card for each diagnosis or operation as in the other system, and then filing these cards so they are readily available. This is somewhat surprising, but our experience indicates that the number of different entities studied is limited enough that this repunching of cards when necessary is less than the three-to-one ratio required for punching a separate card for each diagnostic or operative entry, and thus having the information available in some logical file system.

Another use for punch cards is to prepare a physician's index. It is our experience, however, that there are few occasions when a listing of the different patients for an individual physician would be desired. The two types of inquiries that are much commoner, but still infrequent, are the number of patients admitted by a physician during a certain interval, or the specific patients with a certain disorder or operation who had been on the service of an individual physician. For the former type of inquiry, a simpler source material than a physician's index listing is practical. For the second type of inquiry, a diagnostic or operative listing such as we have described is a ready source of the information. A search of the list of entries under the desired disorder to see which ones have the code for the individual physician is all that is necessary.

There are many advantages to punch card summarization of medical records. Most of these methods have the advantages of easier statistical analysis in many regards, and easier adaptation for cross-diagnosis and cross-operative reference principles. The machine principle of statistical analysis also makes it possible to obtain data that might be overlooked by other methods. Our specific application has the additional advantage of space conservation and time saving in terms of both personnel and machine time. This newly developed method also has a still greater accessibility and flexibility for statistical studies than other methods because of the listing of the many different factors on one punch card.

DICTAPHONE TELECORD speeds procedures at this modern Connecticut hospital

1 Dr. Helen Brown dictates patient history and physical examination report to a TELECORD phone in Bridgeport Hospital. The work goes faster without wasting time making extended notes. The histories are recorded on one centrally located Dictaphone TIME-MASTER that serves the network.



2 Dr. George Tornaritis dictates a discharge summary outside a ward. Now there's no possibility of confusion in the relaying of orders. Being able to do paper work such as this without leaving the floor saves many steps. The hospital has nine conveniently located TELECORD stations.

3 Mrs. Marie Liptak, Medical Records librarian, takes dictated belt from the TIME-MASTER. The system is so simple and economical in operation that the machine is attended only by the regular telephone switchboard operators who call the librarian when a belt is filled.

4 Miss Dagmaar Missick transcribing from the TIME-MASTER, wearing Dictaphone's exclusive "Magic Ear." Since she can fit the typing to her own schedule of work, there are few of the "pile-ups" that cause overtime. One secretary serves this whole TELECORD network.

If your hospital is geared to old-fashioned dictating methods, let Dictaphone make a survey which will show how all your paper work costs, including business office correspondence, can be *cut in half*.

Depending upon your particular needs, the survey may recommend a Dictaphone TELECORD telephone network installation, the amazing new "high-traffic, low-cost" dictation system, or a combination of TELECORD and individual TIME-MASTERs. For details, send in the coupon. No obligation.

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NEWS DIGEST

New England Assembly Sets Record Registration . . . Service Plans Back Federal Reinsurance Program . . . Bachmeyer Elected President of Ohio Association . . . Blue Cross-Blue Shield Advertising Campaign . . . Wisconsin Meeting Report

New England Assembly Reports Record Registration and Overflow Meetings

BOSTON. — Record registration and overflow attendance at most of the sessions featured the 31st annual meeting of the New England Hospital Assembly here March 29 to 31. At 5287, registration reached an all-time high, exceeding last year's attendance by nearly one thousand.

Richard T. Viguers, administrator of the New England Center Hospital here, was named president-elect of the assembly for the coming year. William L. Wilson, administrator of Mary Hitchcock Memorial Hospital at Hanover, N.H., became president during the assembly, succeeding Dr. Frederick T. Hill, medical director of Thayer Hospital, Waterville, Me.

In his presidential address, presented on the final day of the assembly, Dr. Hill urged extension of hospital association activity to include all the people who serve in hospitals. "Too few of the thousands of persons who work in our hospitals have the sincere interest, the thorough understanding and the appreciation of the hospital as a whole, or realize the tremendous opportunities there are for service and the satisfaction there can be in that service," Dr. Hill declared. "It is well enough to conduct meetings and educational programs for various groups, just as we are doing here today, but belonging means much more than being invited. It means a better opportunity for increasing the understanding of the hospital. Can we expect the trustee, from the monthly meeting, the physician, from a ward visit, or the nurse, from a 40 hour a week duty, to achieve all this?"

Dr. Hill urged, especially, the inclusion of physicians and trustees in hospital administrative councils. "What does the average physician know about the cost of caring for a patient in his hospital?" he asked. "About the necessity of conserving supplies or the time of personnel so as to provide services which are most economical and efficient? About the importance of planning admissions and scheduling operations so as to spread the patient load most efficiently and at the same time provide the best of nursing care? About signing discharges promptly, so that the admitting office may know what accommodations shortly may be available?" These and other hospital problems should be taught to physicians in medical school, during internship and in hospital staff meetings, Dr. Hill said. "Some indoctrination into the objectives, the philosophy and the

(*Continued on Page* 162)

New England officers, l. to r.: Secretary, Dr. Philip T. Bonnet; president, W. L. Wilson; treasurer, Lois Bliss; president-elect, Richard T. Viguers.

Blue Cross-Blue Shield Plans Launch National Advertising Campaign

CHICAGO. — A national magazine advertising campaign explaining the purposes and methods of Blue Cross and Blue Shield prepayment plans for hospitalization and medical expense was announced here last month by the Blue Cross and Blue Shield commissions.

The campaign will reach an estimated 71,000,000 readers and will appear in *Life*, *Look* and the *Saturday Evening Post*, Richard M. Jones, director of the Blue Cross Commission, explained.

The first advertisement appeared in the April 5 issue of *Life* magazine; present plans call for nine Blue Cross messages in *Life*, eight in the *Saturday Evening Post*, and eight in *Look*. Blue Shield messages will appear five times in *Life*, five times in the *Saturday Evening Post*, and four times in *Look*, it was explained.

The campaign calls for an expenditure of $750,000 during the coming 12 months, Mr. Jones said. This represents 0.15 per cent of the annual earned subscriber income of Blue Cross and Blue Shield plans, he added.

The need for bringing the Blue Cross and the Blue Shield stories to the American people in a continuing, coordinated way has become increasingly evident, the commission directors said at a meeting here introducing the campaign. "Imitators of the now famous plans are confusing the public," Frank E. Smith, Blue Shield director, stated. "To be imitated is a sign of superiority, but when imitations begin to confuse and misdirect, then clarification is necessary."

Advertising copy emphasizes the not-for-profit character of Blue Cross and Blue Shield and participation of hospitals and doctors in the operation of the plans. "Actually, Blue Cross works like a partnership between you and the

(*Continued on Page* 156)

NEWS...

Robert Bachmeyer Elected President of Ohio Hospital Association

CLEVELAND.—Robert W. Bachmeyer, administrator of the Aultman Hospital in Canton, Ohio, took office as president of the Ohio Hospital Association at the annual banquet held during the convention. Mr. Bachmeyer succeeded Erwin C. Pohlman, administrator of the Grant Hospital in Columbus. Mr. Bachmeyer's father, the late Dr. Arthur C. Bachmeyer, was president of this same state association in 1921. Because Mr. Bachmeyer has resigned from his position in Canton to become adminstrator of the St. Barnabas Hospital in Minneapolis, he held office for only 24 hours. He was then succeeded by Henry N. Hooper, administrator, Cincinnati General Hospital.

Jay W. Collins, executive director of the Euclid-Glenville Hospital and chairman of the program committee for this year's convention, was chosen president-elect. Other officers are: Lee S. Lanpher, administrator, Lutheran Hospital, Cleveland, reelected treasurer; L. C. Rittmeyer, Cincinnati, first vice president, and Sister Mary Eustelle, second vice president. New trustees are Paul Kempe of Toledo and Edward Heyd of Cincinnati.

A registration of 2060 people broke the previous high registration record of 1200.

All of the meetings were built around the theme, "V.I.P., the Patient." The opening morning's session was devoted entirely to a recitation of experiences by patients in hospitals. Mrs.

J. Maynard Dickerson presents award to Sister Mary Sebastian, Lorain, Ohio.

Joseph A. Denk of Euclid, Ohio, described her maternity experience during several pregnancies over the past nine or 10 years, and said that hospitals have greatly improved the care of the patient. She asked that hospitals supply patients' gowns and bathrobes large enough to cover the patient, and then pointed out that volunteers should have a course in silence, silence, that is, about patients' intimate affairs. She continued by saying, "Employes with gripes against other hospital departments, doctors, personnel or patients should be taught not to bring these gripes to the patient."

R. R. Voorhees, Cleveland newspaperman, began his discussion of a surgical experience by saying, "The family physician with the friendly, psychological curative approach to the patient is most important. Such a doctor instills confidence in the patient toward the hospital and everything about the hospital stay." Mr. Voorhees condemned the stuffed shirt attitude of many specialists. "Doctors should pre-

(*Continued on Page* 158)

Ohio trustees, front row, l. to r.: Jay W. Collins; R. W. Bachmeyer, H. N. Hooper, Sister Mary Eustelle. 2d row, l. to r.: H. C. Eader, P. W. Kempe, E. H. Heyd, Rev. W. E. Kappes, E. C. Pohlman and L. S. Lanpher.

Service Plans Support President's Program of Health Reinsurance

Abraham Oseroff

NEW YORK.—Blue Cross and Blue Shield plans support President Eisenhower's proposal for establishment of a health reinsurance corporation, it was announced here during the annual conference of plans.

Blue Cross plans, the Blue Cross statement said, "have carefully studied the proposed reinsurance legislation and . . . feel unanimously that the program for reinsurance is a step in the right direction to facilitate exploratory measures in particular areas of the American population. The plans recognize the sincere intent of President Eisenhower's administration to make comprehensive health coverage available to more people by encouraging and stimulating the expansion of voluntary health programs."

In a more restrained statement, Blue Shield plans endorsed "the basic objectives of the President's message to Congress on health insurance matters." The Blue Shield group, the statement added, "believes in the encouragement of experimentation and expansion in the field of voluntary health insurance."

Blue Shield expects to move ahead to broaden its coverage, whether or not the reinsurance bill is passed, the statement said. However, it added, since Blue Shield is presently "reinsured by the physicians who sponsor Blue Shield plans," it is doubtful the plans would use federal reinsurance even if it were established.

Abraham Oseroff, president of the Hospital Service Association of Pittsburgh, was elected chairman of the Blue Cross Commission, succeeding James E. Stuart of Cincinnati. Robert T. Evans, executive director of the Blue Cross Plan for Hospital Care, Chicago, was elected vice chairman, and Carl M. Metzger, president of the Hospital Service Corporation of Western New York, Buffalo, was named treasurer.

Dr. L. Howard Schriver, president of Ohio Blue Shield, was reelected president of the Blue Shield Commission. Dr. Robert L. Novy, Detroit, is vice president; Dr. Warren W. Fury, Chicago, is secretary, and James O. Kelley, Milwaukee, is treasurer.

NEWS...

Wisconsin Told That Six Parties Are Now Involved in Hospital Service

By ROBERT M. JONES
Waukesha, Wis.

MILWAUKEE.—The annual meeting of the Wisconsin Hospital Association was held here March 18 with a total registration of 265. The theme of the program was "better quality service," and morning sessions were devoted wholly to the professional aspects of hospital care.

Dr. John Hinman, assistant to the director, Joint Commission on Accreditation of Hospitals, stressed the fact that the commission is a voluntary effort on the part of hospitals and physicians to raise standards of patient care. The main reasons for nonapproval of hospitals inspected so far, he asserted, are fire hazards, inadequate review and analysis of clinical work, inadequate supervision of clinical work, insufficient clinical entries on medical records, and finally, high morbidity, normal tissue at postmortem, unwarranted cesarean section, and high infant and maternal mortality rates.

Dr. Harry F. Becker, field secretary of the Michigan State Medical Society's advisory committee to the Michigan Hospital Service, then discussed trends and utilization of prepayment plans. In a Michigan survey completed last October it was found that abuse of hospitalization was evident in 33 per cent of the cases paid for by third parties and in 14 per cent of self-pay cases. In each case of misuse three or four parties are involved—patient, doctor, hospital, and the third-party payer if any. The doctor alone is not to blame for this misuse, he declared. The Michigan Hospital Service is now conducting a campaign among all groups to help reduce this problem but results are not as yet known since the campaign is only three months old.

Karl H. York, administrator, St. Luke's Hospital, Racine, stressed the hospital's rôle in cooperating with Blue Cross in all areas as well as in helping to eliminate misuse. Leon Wheeler, executive director of the Associated Hospital Service of Wisconsin, said that the 25 per cent rate increase in Blue Cross premiums going into effect May 1 would probably not have been necessary except for the abuse of existing contracts.

James Gersonde, executive secretary of the Illinois Hospital Association, spoke on regional hospital councils at the luncheon. Their purposes are to assist in legislative action, change ideas, help develop a strong state association, and keep the state association informed on local problems, he said. The annual award of merit was presented by Dr. Harold Coon to Sister Bernadette, administrator, St. Joseph's Hospital, Milwaukee.

The final speaker, Ray Brown, superintendent of the University of Chicago Clinics, summed up the meeting. He pointed out that actually six parties are now involved in hospital service: patient, doctor, hospital, Blue Cross or commercial insurance company or government payer, the public, and, finally, industry, which in many cases now pays for its employes the total premium for prepayment hospital insurance. He urged more thorough study of the misuse problem before coming to definite conclusions.

At the business session the Rev. A. H. Schmeuszer, administrator, Evangelical Deaconess Hospital, Milwaukee, turned the presidency over to Mrs. Mary Evans, administrator, Beloit Municipal Hospital, Beloit. Stuart K. Hummel, administrator, Columbia Hospital, Milwaukee, was named president-elect.

Blue Cross-Blue Shield Launch Campaign

(*Continued From Page* 152)

hospitals," the initial advertisement in *Life* stated. Organization of Blue Cross and Blue Shield as community services, rather than insurance companies, is also stressed in the messages.

Selection of *Life*, *Look* and the *Saturday Evening Post* as the advertising media was explained on the basis of their combined mass circulation and the quality of readership. Especially, it was explained, these magazines reach 60 per cent of the executive group in America, including proprietors of businesses, professional men and top level executives. "They also reach about 60 per cent of the white collar group, salesmen and people in clerical and office jobs," the commission announcement stated. "They reach 35 per cent of craftsmen, foremen, machine operators and nonfarm laborers. Thirty-five per cent of service workers and 32 per cent of farmers and farm laborers will also be reached. No other combination of national publications could offer this range."

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time's test backs your choice of FACING TILE

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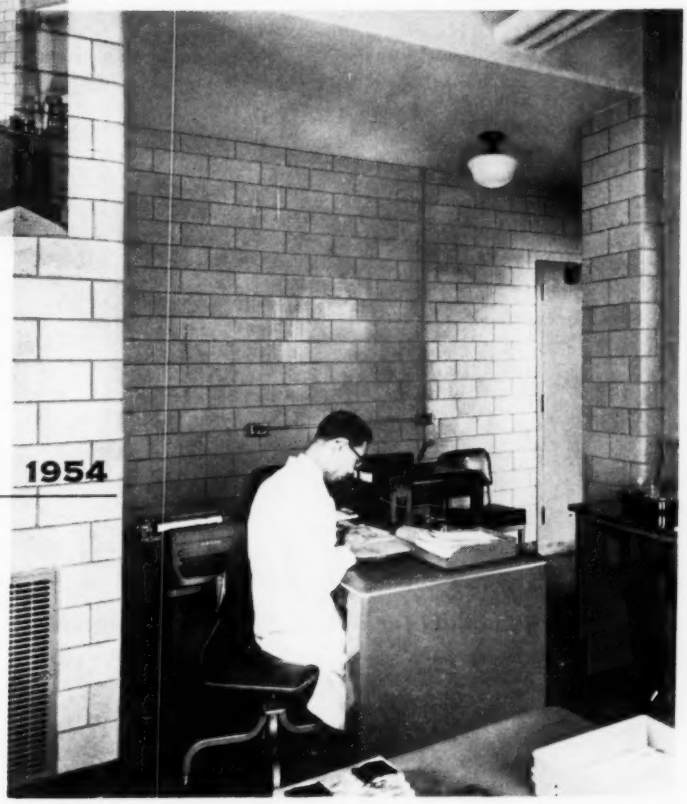

1954

This typical installation of glazed structural Facing Tile in the 13-year old Lebanon Hospital, Bronx, New York, looks as clean and attractive today as it did when the building first opened.

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CONSTRUCTION ECONOMY—Made in large modular sizes, Facing Tile lays up fast, with a minimum of cutting and fitting, builds a load-bearing wall and finish in one labor-saving step.

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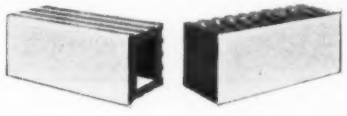

NEWS...

Ohio Association Elects Bachmeyer

(*Continued From Page* 154)

pare their patients for the hospital experience and explain how the patient can help to make the hospital stay a happy time," said Mr. Voorhees.

At the Tuesday afternoon session various people on the hospital team offered suggestions as to how to treat the patient. James G. Harding, administrator, Cleveland Clinic Hospital, discussing the patient from the admitting standpoint, warned: "Don't promote efficient procedures at the expense of human understanding of employes or patients." He urged hospitals to put explanatory booklets in the hands of all patients so that they would understand just what to expect when they come to the admitting office. William E. Claypool, assistant administrator, University Hospital in Columbus, described a stork club preview booklet which the hospital provides to expectant mothers.

Discussing financial relations with patients, William B. Forster, assistant director, City Hospital of Akron, asked, "How can we maintain good public relations and still collect the money people owe us?" Mr. Forster said, "You must make a person feel that you approve of him and want to be his friend and really want to help him. The first contact with the admitting officer or credit officer who interviews the patient is all-important." He explained that when the patient or responsible party first comes into the hospital, the admitting or credit officer should see that this person clearly understands the payment terms offered and the reasons for these terms. He said that when the patient is discharged it is most important for the cashier to use the payer's name several times and to greet the departing patient with a pleasant smile and a sincere "Thank you" for the payment.

Wednesday morning's session was devoted to the thoughts of some of the professional people in the hospital on caring for patients. Dr. Robert J. Burkhard, formerly chief resident, City Hospital of Akron, said that the patient must be converted from a feeling of apprehension to a sense of security and a feeling of serenity. He pointed out that every patient should be given a verbal summary of his case, a clear understanding of his progress, and complete instructions from the doctor before he is discharged to his home.

Edith Cassidy, chief medical technologist, Springfield City Hospital, asked what the medical technologist as a good neighbor can do to help the patient, and pointed out that the medical technologist should always explain to the patient the reasons for a test and prepare the patient mentally for it.

Dr. John D. Osmond, director of radiology, Euclid-Glenville Hospital, Euclid, explained that radiologists consider themselves consultants to other doctors, rather than the patient's private physician. He emphasized the importance of scheduling work in the department of radiology so as to avoid the delays which always annoy patients. Like Mrs. Denk, who discussed the situation from the patient's standpoint, Dr. Osmond urged that hospital people always avoid any unnecessary exposure of the patient.

An overflow crowd, the largest ever to attend any session of the Ohio Hospital Association, testified to the great

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interest of all people in the Wednesday afternoon session devoted to nursing. John H. Hayes, chairman of the National Committee on Careers in Nursing, opened the meeting by warning against taking too many patient care duties away from registered nurses. "Patient anxieties," said Mr. Hayes, "are stilled by the mere presence of a friendly registered nurse." He pointed out that hospitals with schools of nursing are burdened with added costs which should be shared by the entire community and federal, state and local governmental units.

Helen M. Bryan, R.N., director of nursing service, Youngstown Hospital Association, Youngstown, discussed professional nursing and pointed out that the growing complexity of medical care requires that registered nurses keep up to date at all times through continuing in-service educational programs, so that they in turn can instruct and supervise the practical nurses, nurse's aides and orderlies.

Mildred Smith, president of the Practical Nurse Association of Ohio, said that many practical nurses who are not graduates of approved schools want a chance for further education and training in the hospitals where they are working.

In the discussion period following the presentation of the talks on nursing a lively debate arose between Mr. Hayes and Miss Bryan on the problem of registered nurses' becoming too technical and losing interest in tender, loving care.

Thursday morning's session was devoted to the service department's rôle in patient care. Sister M. Romuald, S.C., dietitian, Good Samaritan Hospital in Cincinnati, urged that dietitians pay attention to the attractiveness of food service, as well as to the proper nutritional balance. Later comment from the panel, however, warned dietitians not to carry their traditional ideas of attractiveness so far that some of the newer types of highly satisfactory food service are shut out. Sister Romuald said, "Don't spoil high quality food by serving it lukewarm or cold."

William O. Bohman, administrator of the Middletown Hospital, discussed the maintenance department and said, "A realization of the maintenance department's great importance to the whole hospital must start in the adminstrator's office."

Everett W. Jones of The Modern Hospital Publishing Company summed up and commented on the main points raised by all speakers covering the theme "V.I.P.—the Patient."

On Thursday afternoon the Ohio Industrial Commission presented safety plaques to 31 Ohio hospitals. Top honors were awarded to the St. Joseph's Hospital of Lorain, Ohio.

At a sectional meeting of Ohio Blue Cross Plans Walter A. Robinson, superintendent of Ohio's division of insurance, charged that high pressure salesmanship and questionable advertising practices of a few insurance companies handling health insurance have tended to shake public confidence in all phases of insurance. "We are working with the industry to eliminate the complaint that in many cases a policy is canceled immediately after a claim is paid, with no consideration of how small the claim or the length of time the policy has been in force," Mr. Robinson explained.

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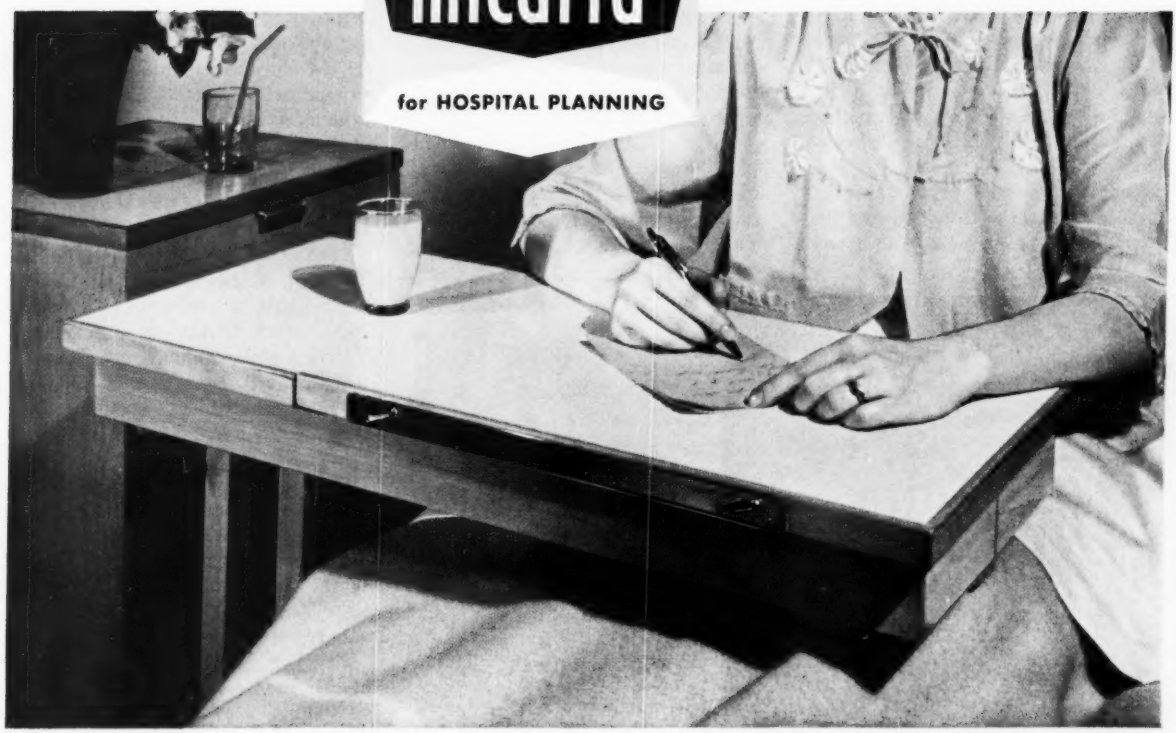

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NEWS...

Insurance Articles Put Into Booklet

CHICAGO.—The six articles, "How to Buy Insurance for the Hospital," by Dwight W. and Richard C. Sleeper, which appeared in The MODERN HOSPITAL from July to December 1952, are now available in booklet form, The Modern Hospital Publishing Company announced here last month.

The booklet was prepared by the authors in response to widespread demand from hospital and insurance people following publication of the articles in this magazine, it was explained.

Dwight W. and Richard C. Sleeper are insurance consultants whose extensive experience in analyzing hospital insurance problems was summarized in the original series of articles, which won The MODERN HOSPITAL Gold Medal Award for the best original articles published in 1952. The Sleepers are now preparing for early publication a new series of articles dealing specifically with general liability and professional malpractice insurance problems.

Information on the availability of the booklet, "How to Buy Insurance for the Hospital," may be obtained by writing to Dwight W. Sleeper at the Insurance Buyers Council, Harwich Port, Mass.

Teachers College Did Research on Nursing Film

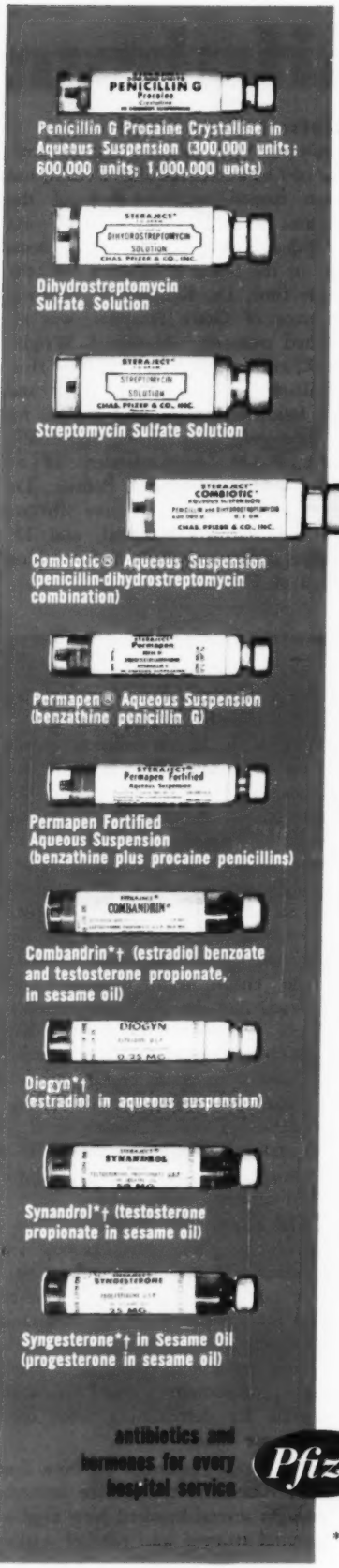
CHICAGO.—In the article, "Nurses Team Up for Better Care," on page 91 of The MODERN HOSPITAL for March 1954, it was erroneously implied that Wayne Comer of Johnson & Johnson had conducted the studies of team nursing from which the talking slide film, "Team Relationships in Nursing Care," was made.

Actually, the survey directed by Mr. Comer was undertaken to determine interest and concern among nurses in various nursing problems; on the basis of this study indicating keen interest in team nursing, Johnson & Johnson decided to make the slide film on that subject. As indicated in the text of the article, the slide film was then developed with the cooperation of Eleanor Lambertsen, author of the book, "Nursing Team Organization and Functioning."

"Study and experimentation in team nursing started at Teachers College, Columbia University, four years ago and since that time research staffs have been continually assigned to this project," Mrs. R. Louise McManus, director of the division of nursing education at Teachers College, said. "Miss Lambertsen is currently directing the study.

"Some time ago Teachers College called Mr. Comer's attention to this important research project and cooperated fully with him and his staff in the preparation of the filmstrip upon which the article in your March issue is based. Arrangements were made for him to utilize the manuscript of Miss Lambertsen's book, 'Nursing Team Organization and Functioning,' prior to its publication with the understanding that proper recognition would be given to the rôle of the Teachers College Division of Nursing Education in the research and Miss Lambertsen as author and director of the project.

"Miss Lambertsen gave generously of her time and energies in the preparation of the script."



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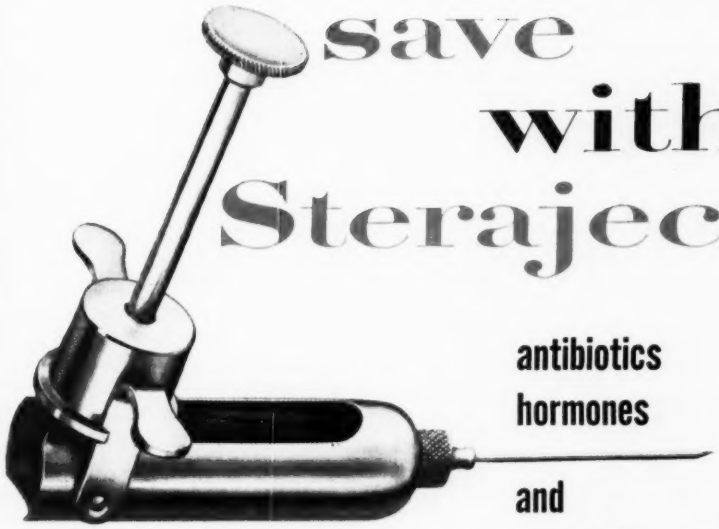

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NEWS . . .

Films Will Recruit Medical Technologists

WASHINGTON, D.C. — Two movies to interest young Americans in careers as medical technologists are to be made under a grant of $30,000 from the American Cancer Society.

A simultaneous grant of $15,000 from the National Cancer Institute will make it possible to purchase prints of the films for use by schools, guidance groups, rural audiences such as the 4-H Clubs, the Y.M.C.A. and Y.W.C.A., and other organizations.

Both grants have been made to the National Committee for Careers in Medical Technology, a newly formed organization sponsored by the American Society of Medical Technologists, the American Society of Clinical Pathologists, and the College of American Pathologists.

One of the films will be a 20 minute color movie for classrooms and group meetings.

Detroit Council Officers

DETROIT. — Jacques Cousin, director of Oakwood Hospital, Detroit, has been named president-elect of the Detroit Area Hospital Council. As president-elect he also becomes a member of the board of trustees. At the same time, Dr. Kenneth B. Babcock, director of Grace Hospital, was re-elected treasurer. Marion J. Wright, R.N., associate director of Harper Hospital, was elected vice president and the following were elected trustees for a three-year term: Sister Mary William, R.S.M., superintendent of St. Joseph Mercy Hospital, Pontiac; Dr. Robin C. Buerki, executive director of Henry Ford Hospital, and Dr. Julien Priver, director of Sinai Hospital of Detroit.

New England Assembly Has Record Attendance

(*Continued From Page* 152)

problems of the hospital would do much to dispel misunderstanding, even antagonisms, which can be so detrimental both to the hospital and staff," he concluded.

The educational program conducted by the American Hospital Association was described in an address by Ritz E. Heerman of Los Angeles, A.H.A. president. During the last year, he said, some 1200 hospitals had sent more than 2000 students to A.H.A.-sponsored institutes, in a continuing effort to improve hospital methods. "The program covers a variety of subjects from laundries to ledgers," Mr. Heerman said. "It brings together the best minds in the varied fields and actually in a larger educational enterprise than many small colleges."

Nevertheless, the A.H.A. president added, "We have only scratched the surface in bringing to bear the facilities of research, in-service education and attention to the multiplicity of problems which are presented to us from day to day." He described the proposed Institute of Hospital Affairs as a desirable program for research in hospital administration and allied fields. "Every hospital administrator and trustee should be interested in this development in order to give patients better care and also eliminate hazards," Mr. Heerman concluded.

One of the largest overflow crowds at the assembly attended a luncheon to hear Mrs. Oveta Culp Hobby, U.S. Secretary of Health, Education and Welfare, explain President Eisenhower's health program. Mrs. Hobby strongly recommended passage of the bill to effect the President's proposal to establish a federal reinsurance corporation. The reinsurance program would "enable health insurance plans to reach into the area of catastrophic illness or pay the costs of early diagnosis and treatment of chronic disease," she said. "It would enable the aged or other people now considered uninsurable to obtain the benefits of hospital and medical care insurance. It might, in some instances, lower premium rates," she added.

The reinsurance program is not a subsidy program, Mrs. Hobby emphasized. "It will not regulate insurance companies," she stated. "In return for a payment to the reinsurance fund, the carriers would be insured against any abnormal losses. The federal government would establish criteria for determining what other plans are sound."

An annual feature of the New England Assembly, the trustee institute, brought several hundred New England hospital trustees into parallel sessions

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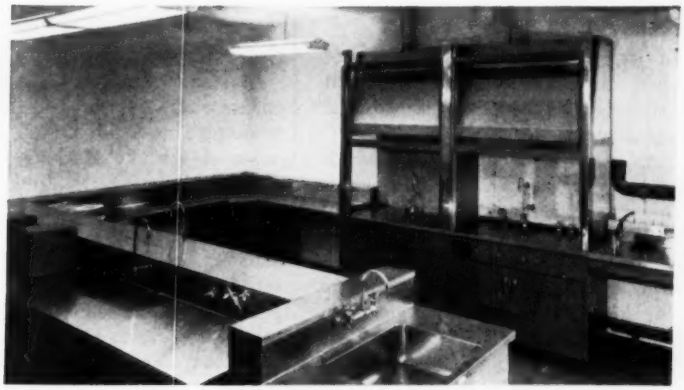

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for large and small hospital groups, where discussions centered on medical standards and problems of hospital accreditation.

A convention innovation which speeded registration of the record crowd on opening day was a perforated registration card on which the visitor was permitted to fill out his own identification badge, then separate this from the rest of his registration form, and go on his way without the necessity of standing in line while a clerk made out his identification badge.

In addition to Mr. Viguers, other officers elected by the assembly were: treasurer, Lois A. Bliss, R.N., administrator of Franklin Hospital, Franklin, N.H.; secretary, Dr. Philip T. Bonnet, administrator, Massachusetts Memorial Hospitals, Boston; and trustees, Norman R. Brown, administrator, Claremont General Hospital, Claremont, N.H., and Charles W. Capron, administrator, Kerbs Memorial Hospital, St. Albans, Vt.

Southeastern Speakers Stress "Human Engineering"

(*Continued From Page 90*)

engineering and maintenance departments. He discussed the importance of special orientation and training for all mechanics working in the hospital.

George Linney, assistant administrator of the Georgia Baptist Hospital in Atlanta, gave some impressive figures showing how proper installation and operation of sprinkler systems will reduce fire insurance premiums.

Thursday morning's general meeting heard Dr. Robert Cohen, a neuropsychiatrist at General Rose Hospital in Denver, describe the problems involved in human engineering.

Robert Hudgens, administrator of the Lynchburg General Hospital, Lynchburg, Va., and regent of the American College of Hospital Administrators, closed the session on human engineering by pointing out that hospital executives must recognize training as a continuing process for old and new employes.

The second session of the small hospital group was devoted to labor-saving devices and methods and a review of the public attitude toward hospitals. C. S. Worthy, chairman of the Crisp County Hospital Authority in Cordele, Ga., pointed out the public relations value of increasing Blue Cross and Blue Shield coverage in lessening patients' "gripes" about their bills.

Roy Richards, chairman of the Carroll County Hospital Authority in Carrollton, Ga., said that we must face our shortcomings, admit our faults and study ways and means to correct them. Board members, he said, do not know enough about the questions and doubts in the minds of citizens about hospitals.

A surprising feature of the conference was the large turnout at the federal hospital breakfast meeting on Friday. Approximately 300 people heard Fred A. McNamara, chief of the hospital section, U.S. Bureau of the Budget, discuss cooperation between governmental and voluntary hospitals. He warned voluntary hospital people that their institutions have no monopoly on, or sole responsibility for, hospital care in this country. He urged them to recognize the place of the federal hospital system in the nation's health program.

The theme for the final section meeting for small hospitals was

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NEWS...

"Teamwork for Better Patient Care." Everett W. Jones, Chicago, a trustee of Provident Hospital, Chicago, told the delegates that trustees generally must realize that hospitals are complicated, difficult-to-operate organizations, and that because of this they must pay salaries high enough to attract and hold the ablest executive ability in their communities. Mr. Jones pointed out the obligation of trustees in seeing that local units of government pay full cost for the care of indigent patients and that Blue Cross and Blue Shield insurance be sold throughout their areas.

In discussing the administrator's rôle in patient care, Robert A. Ivy, administrator of Doster Hospital and Clinic, Columbus, Miss., said, "Traditionally our hospitals have been islands of isolation. This concept must end. We now know that hospital administrators and other executives must take an active part in community activities."

Dr. Enoch Callaway of the West Georgia Cancer Clinic, La Grange, Ga., pointed out that if hospital trustees and administrators would try to understand and recognize the inner independence of thought and action of doctors, better cooperative relations could be achieved. If the active interest and cooperation of the attending staff can be achieved, he said, doctors individually and collectively can do much to help administration improve operations and cut costs.

The concluding session Friday was devoted to hospital-community relations, at which the featured speaker was Luke Greene, city editor of the *Atlanta Constitution*. "We newspaper folk and you hospital people should get to know each other better," said Mr. Greene. Hospitals are the most difficult organizations in the area to deal with when it comes to getting necessary information, he said. They should stop using ethics as an excuse for the suppression of news. Mr. Greene pointed out that newspapers in the larger cities are developing specialists in medical and hospital news, which he believes will help improve relations between newspapers and hospitals.

Officers elected by the conference were: president-elect, D. O. McClusky Jr., Druid City Hospital, Tuscaloosa, Ala.; vice president, John F. Wymer Jr., administrator, Good Samaritan Hospital, West Palm Beach, Fla. Elected as a delegate to the board of directors was Frank S. Groner, administrator, Baptist Hospital, Memphis, Tenn. Pat N. Groner, adminstrator, Baptist Hospital, Pensacola, Fla., was reappointed secretary-treasurer.

Allied groups meeting concurrently with the Southeastern Hospital Conference elected the following presidents: Dietitians, Margaret Dykes, dietary consultant of the Division of Hospital Service, Georgia Health Department; pharmacists, Mrs. Oma Dell Pittman of the Anniston Memorial Hospital, Anniston, Ala.; medical record librarians, Gertrude McCalip of the Baptist Memorial Hospital, Memphis, Tenn.; anesthetists, Ruth Dixson of the Baptist Hospital, Birmingham, Ala.

At the end of the conference, John W. Gill, business manager of the Street Memorial Clinic and Mercy Hospital, Vicksburg, Miss., succeeded Charles W. Holmes of Memphis as president.

Practitioners Seek Hospital Privileges

(*Continued From Page* 85)

well qualified to do surgery, he may find his practice curtailed by surgical specialists who feel that only members of their organization are entitled to wield a scalpel.

"The American Academy of General Practice has no desire to castigate other members of the medical profession," Mr. Cahal stated. "Conflicts are little more than a waste of time that might better be spent on really constructive programs. Emphasis on the unethical acts of a few unscrupulous surgeons should not be permitted to obscure the fact that 99 per cent of America's doctors are competent, honest and altruistic. We feel that a doctor's competence should be judged by his ability—not by the presence of a framed certificate on the wall of his office."

Registration at the assembly exceeded 6000, it was reported, an increase of 25 per cent over any previous registration figure. In his annual report to the delegates, Mr. Cahal said 473 academy members had been dropped from membership for failure to complete postgraduate study requirements. Each member is required to do 50 hours of postgraduate work each year to maintain active membership status, he said.

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ABOUT PEOPLE

(*Continued From Page* 88)

John I. Spreckelmyer, manager of the Veterans Administration Center at Bath, N.Y., has been appointed manager of the V. A. Center at Dayton, Ohio, succeeding **B. C. Moore,** who retired March 31. At the same time it was announced that **Dr. Thomas J. Hardgrove,** manager of the V.A. Hospital, American Lake, Wash., will become manager of the new 1000 bed neuropsychiatric hospital now under construction at Sepulveda, Calif.

Edward J. Thoms has succeeded Bernard C. Dyer as administrator of Brooklyn Thoracic Hospital, Brooklyn, N.Y. Mr. Thoms has been administrator of the Crotched Mountain Foundation, Greenfield, N.H.

Gerhard A. Krembs, administrator of Ishpeming-Negaunee Hospital, Ishpeming, Mich., for the last two years, has resigned to become administrator of Bayonne Hospital and Dispensary, Bayonne, N.J. A graduate of the Columbia University course in hospital administration, Mr. Krembs was previously administrator of Door County Memorial Hospital, Sturgeon Bay, Wis., and Algoma Hospital, Algoma, Wis. He will be succeeded at Ishpeming by **Kenneth Moburg,** former administrator of the Schoolcraft Memorial Hospital, Manistique, Mich. Mr. Moburg is a graduate of Northwestern University's course in hospital administration.

Kenneth Moburg

G. A. Krembs

Frank B. Hamilton has been promoted from the position of administrative assistant to that of assistant to the manager of the Veterans Administration Hospital, Houston, Tex.

W. O. Williams has been appointed administrator of the new 36 bed Jackson Hospital, Jackson, Ala. He was formerly administrator of Marvin Kendrick Memorial Hospital, Luverne, Ala.

Dr. J. B. Dugan

Dr. J. Brooks Dugan is the new medical director of Pinel Hospital, a psychiatric sanitarium in Seattle. Dr. Dugan joined the Pinel staff in January 1952 and has served as acting medical director since June 1953. He is a graduate of Northwestern University Medical School and received graduate training in psychiatry at the Menninger Foundation School of Psychiatry, Topeka, Kan.

Frank C. Haythorn has been named administrator of Cherokee County Hospital, Gaffney, S.C. He was formerly administrator of Randolph Hospital, Ashboro, N.C.

Olaf T. Moline has been selected as acting administrator of Hinsdale Sanitarium and Hospital, Hinsdale, Ill., replacing **Norman C. Taylor** who has been administrator since April 1950. Mr. Moline has been assistant to the administrator for the last three years.

Cheney Ellerbe is the new administrator of Fairmont General Hospital, Fairmont, W. Va. His former position was that of assistant administrator of Orange Memorial Hospital, Orlando, Fla.

(*Continued on Page* 170)

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G. DeWitt Brown, formerly of Corbin, Ky., has been appointed assistant to the administrator at Central Baptist Hospital, Lexington, Ky.

Victor D. Bjork resigned his position of administrator of Hadley Memorial Hospital, Hays, Kan., to assume a similar post at Flower Hospital, Toledo, Ohio, succeeding **Elmer Paul.**

Robert E. Wallace, former administrator of Wood River Township Hospital, Wood River, Ill., has been appointed head of Dixon State School, Dixon, Ill., it has been announced by **Dr. Otto L. Bettag,** state welfare director. Other changes in Illinois state institutions announced by Dr. Bettag include the selection of **E. J. Uffelman** as superintendent of the Illinois Security School, Menard, and **Daniel Manelli** as head of Peoria State Hospital, succeeding **Dr. H. B. Knowles.**

Dr. Paul R. Copeland will succeed **Dr. Blanton E. Russell** as manager of the Veterans Administration Hospital at Beckley, W. Va. Dr. Copeland was formerly chief medical officer of the V.A. Center, Martinsburg, W. Va.

Dr. Murl J. Robertson, acting manager and chief of professional services at the Veterans Administration Hospital, Miles City, Mont., has been confirmed as manager.

Department Heads

J. Louis Read has been appointed director of food service at Mount Sinai Hospital of New York. Mr. Reed was manager of the Hotel Henry Perkins, Suffolk County, New York. Previous experience included managership of the Harvard Club, Boston, and assistant managership at the Waldorf-Astoria Hotel. He once headed the commissary department for Pan-American Airways in Liberia. He holds a degree in hotel administration from Cornell University.


Celia Cranz, R.N.

Celia Cranz, R.N., director of the school of nursing at Akron City Hospital, Akron, Ohio, since 1926, has been appointed general secretary of the Ohio State Nurses' Association. She succeeds **Elizabeth P. August, R.N.,** who has resigned from this position which she held since 1923, to return to private life. Mrs. August's resignation will become effective August 31; Miss Cranz began her new duties in April.

Sister M. Evarista Seibers has been made director of nursing and nursing service at St. Elizabeth Hospital and School of Nursing, Covington, Ky. She replaces **Sister Mary Anthony,** who has been transferred to St. Margaret Hospital, Kansas City, Kan. **Sister M. Evarista** has her master's degree in nursing from the Catholic University of America, and is second vice president of the Kentucky State Association of Registered Nurses. In March she was appointed by the governor to the State Board of Nurse Registration and Nursing Education.

John M. Boyer has been appointed director of personnel and community relations at Aultman Hospital, Canton, Ohio. He was formerly in Florida with the Halifax District Hospital, Daytona Beach, and Wuestoff Memorial Hospital at Rockledge. Before this he was associated with the University of Illinois Research and Education Hospital, Chicago, and with Wesley Memorial Hospital, Chicago, as director of personnel.

Estelle H. Collins, formerly director of nursing education at Aultman, has been given top administrative direction of both the nursing service and the school of nursing, with the title of director of nursing.

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* Levine, S. A. Some Harmful Effects of Recumbency in the Treatment of Heart Disease. J.A.M.A. 126:80-84, Sept. 9, 1944. Levine, S. A. and Lown, B. "Armchair" Treatment of Acute Coronary Thrombosis. J.A.M.A. 148:1365-1369, April 19, 1952. Levine, S. A. The Myth of Strict Bed Rest in the Treatment of Heart Disease. A.H.J. 42:406-413, September, 1951.

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Deaths

Rev. Francis P. Lively, 42, president of the Catholic Hospital Association, died of a heart attack in March. Father Lively became president of the association at the 1953 convention in Kansas City, Mo. In his own diocese, Brooklyn, N.Y., he was associate director of health and hospitals, director of nursing education, moderator of the Catholic Physicians Guild, and moderator of the Catholic Nurses Association. He served on the executive committee on accreditation policies of the National League for Nursing.

COMING EVENTS

AMERICAN ASSOCIATION OF HOSPITAL ACCOUNTANTS, Annual Institute on Hospital Accounting, Indiana School of Business, Bloomington, July 18-23.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Sheraton-Cadillac Hotel, Detroit, Oct. 4-8.

AMERICAN ASSOCIATION OF NURSING HOMES, Annual Convention, Seelbach Hotel, Louisville, Ky., Oct. 18-20.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Annual Meeting, Palmer House, Chicago, Sept. 11-13. ***Institutes for Hospital Administrators:*** 6th Midwest Institute, Colorado Woman's College, Denver, June 14-18; 6th New York Institute, Columbia University, New York City, June 21-July 2; 6th Western Institute, Stanford University, Palo Alto, Calif., Aug. 2-13; 22d Chicago Institute, University of Chicago, Aug. 31-Sept. 10; 5th Chicago Advanced Institute, University of Chicago, Sept. 6-10; 9th Southern Institute, Richmond, Va., Nov. 1-5. Conference on Human Relations, Hotel Lowry, St. Paul, May 10, 11.

AMERICAN DIETETIC ASSOCIATION, Commercial Museum and Benjamin Franklin Hotel, Philadelphia, Oct. 26-29.

AMERICAN HOSPITAL ASSOCIATION, Navy Pier, Chicago, Sept. 13-16.

AMERICAN MEDICAL ASSOCIATION, San Francisco, June 21 to 25.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Annual Meeting, Hotel Baker, Dallas, Tex., Oct. 21-Nov. 3.

AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS, Hotels Di Lido and Delano, Miami Beach, Fla., June 13-17.

AMERICAN SURGICAL TRADE ASSOCIATION, Grand Hotel, Mackinac Island, Mich., June 7-9.

CALIFORNIA HOSPITAL ASSOCIATION, Fresno Hacienda, Fresno, Oct. 28, 29.

CANADIAN NURSES' ASSOCIATION, 27th Biennial Meeting, Banff Springs Hotel, Banff, Alta., June 7-11.

CATHOLIC HOSPITAL ASSOCIATION, Convention Hall ,Atlantic City, N.J., May 17-20.

CONFERENCE OF CATHOLIC SCHOOLS OF NURSING, Atlantic City, N.J., May 15, 16.

ILLINOIS HOSPITAL ASSOCIATION, Hotel Abraham Lincoln, Springfield, Dec. 2, 3.

INDIANA HOSPITAL ASSOCIATION, Institute on Legal Aspects of Hospital Administration, Student Union Building, Indiana University Medical Center, Indianapolis, June 10, 11.

KANSAS HOSPITAL ASSOCIATION, Baker Hotel, Hutchinson, Nov. 11, 12.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Spring Meeting, Hotel du Pont, Wilmington, Del., May 18; annual conference, Hotel Shoreham, Washington, D.C., Nov. 15, 16.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 26-28.

MISSISSIPPI HOSPITAL ASSOCIATION, 23d Annual Convention, Hotel Heidelberg, Jackson, Oct. 13-15.

NATIONAL EXECUTIVE HOUSEKEEPERS ASSOCIATION, Biennial Congress, Drake Hotel, Chicago, June 2-5.

NATIONAL TUBERCULOSIS ASSOCIATION, Atlantic City, N. J., May 17-21.

NEW MEXICO HOSPITAL ASSOCIATION, Hilton Hotel, Albuquerque, May 7, 8.

TENNESSEE HOSPITAL ASSOCIATION, Hotel Greystone, Gatlinburg, Tenn., May 20-22.

TEXAS HOSPITAL ASSOCIATION, Shamrock Hotel, Houston, May 18-20.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 3-5.

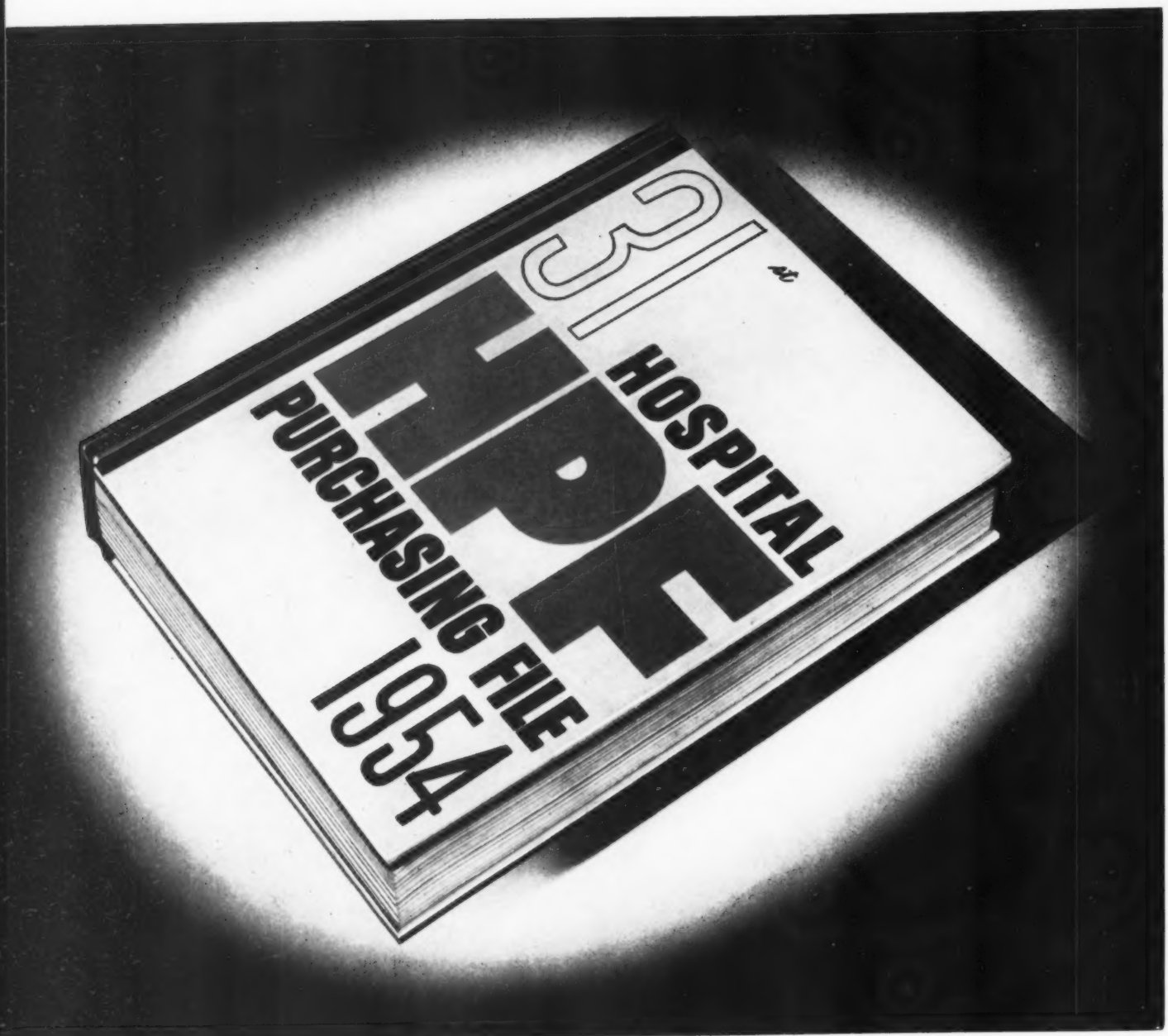
UPPER MIDWEST HOSPITAL ASSEMBLY, Hotels Lowry and St. Paul, St. Paul, May 12-14.

WASHINGTON STATE HOSPITAL ASSOCIATION, Chinook Hotel, Yakima, Sept. 29, 30.

1955

WISCONSIN STATE HOSPITAL ASSOCIATION, Milwaukee, March 17,

ABC...



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Hill-Rom Company, Inc.	CA
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Jarvis and Jarvis, Inc.	CA
Kenmar Mfg. Co.	CA
Kent Company, Inc., The	CB
Kenwood Mills	CC
Kuttnauer Manufacturing Co.	CC
Legge Co., Inc., Walter G.	CB
Luminous Equipment Co.	CA
Midland Laboratories	CB
Royal Metal Manufacturing Company	CA
Simmons Company, Hospital Division	CA
Spencer Turbine Co.	CB
Superior Sleeprite Corp.	CA
Tomlinson of High Point, Inc.	CA

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THE BOOKSHELF

DESIGN AND CONSTRUCTION OF GENERAL HOSPITALS. *By the U.S. Department of Health, Education and Welfare, Public Health Service. New York: F. W. Dodge Corporation; Chicago: The Modern Hospital Publishing Co. Pp.* 214. *Price,* $12.

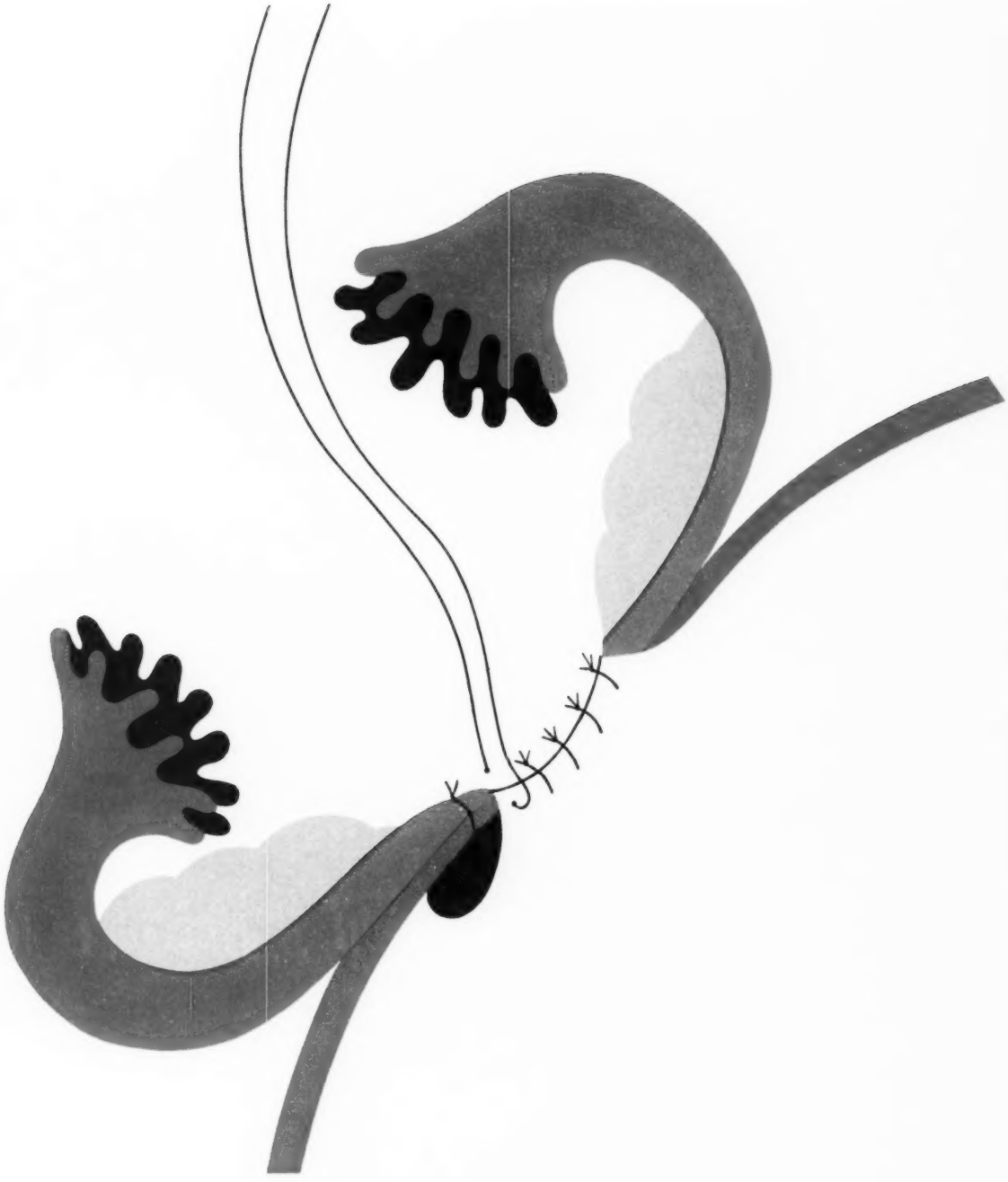
The United States Department of Health, Education and Welfare, Public Health Service, has made a most valuable contribution to the hospital field in this publication. Appreciation is also due the F. W. Dodge Corporation and The MODERN HOSPITAL magazine for making it possible to give this text wide distribution. The distinguished list of forewords speak for the excellence of this publication. Recognition is due Marshall Shaffer and others for the excellence of the work, for its rational approach to hospital planning and construction, and the logical arrangement of subject matter, the completeness and comprehension of each step.

This text is valuable to governing bodies of hospitals, administrators, heads of departments and architects in planning the new hospital. It is of particular value to the student of hospital administration and should stand high in his list of reference books.

The rapid and intricate advances of medical science have made the mid-century hospital a highly complex and specialized institution. No longer is it merely a custodial institution; here in the modern hospital are massed the forces of science to diagnose, treat and control the diseases of mankind. Concurrent with this have been the advances of scientific management and services. Today it may truly be said that hospital planning has assumed the rôle of an art and a science. The new text "Design and Construction of General Hospitals" evidences this trend.

With the current nationwide trend toward expansion of health facilities, the subject of hospital planning and architecture has assumed a position of vital importance. New hospitals are mushrooming, additions are being built to older ones, and the trend shows every sign of continuing. In all too many cases, however, one hears complaints that a brand new surgery has all the most modern equipment, but insufficient locker space for surgeons; that not enough elevators are included to handle the load; that traffic of carts in and out of the kitchen crowd the corridors at mealtime, and even that the position of the receiving entrance causes traffic jams which block the entrance to the emergency department. Incorrect judgment in allotment of space continues to cause many regrets and necessitates costly alterations.

These and many other errors could have been avoided if those responsible for planning had had available the necessary knowledge based on the best judgment and experience in the field that is contained in this volume. The book summarizes 11 years of research by Public Health Service, in cooperation with the hospital field. It is a compendium of positive plans based on principles that have proved themselves and that are described in the text. Where other works describe mainly the principles basic to hospital planning and construction, this one translates the principles into schematic drawings and illustrates how they can be carried out in general hospitals as small as eight beds (nursing units or community clinics) and as large as 200 beds. Even more, it provides detailed



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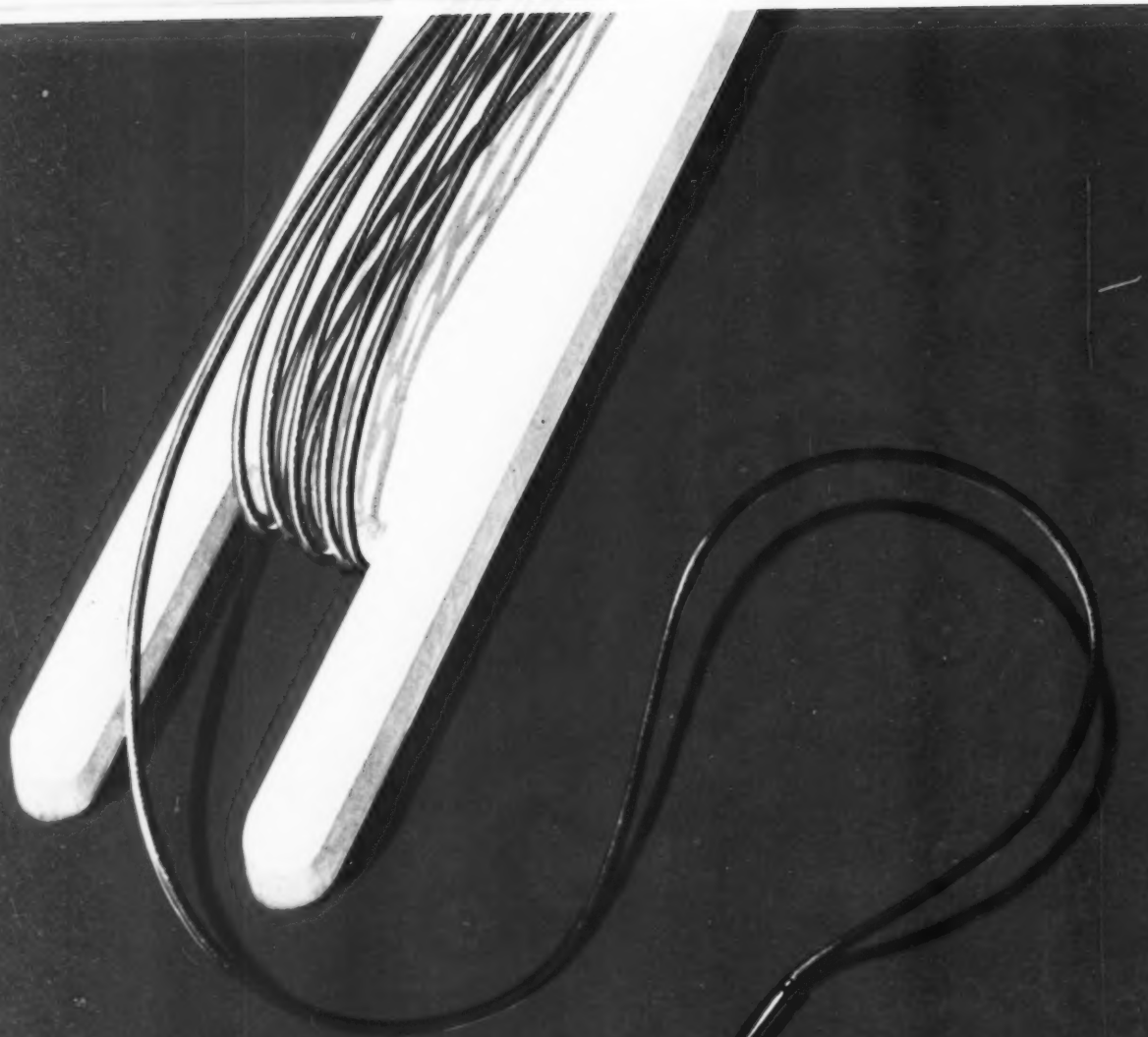

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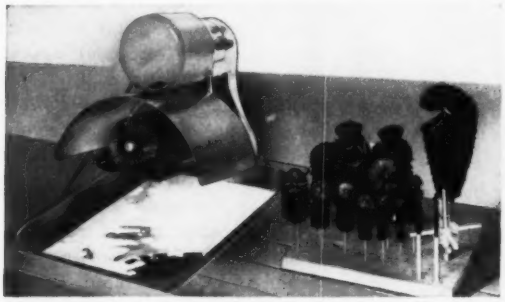

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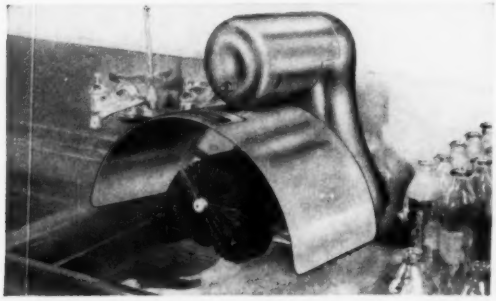

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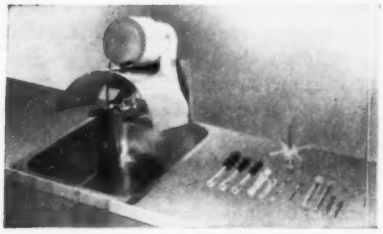

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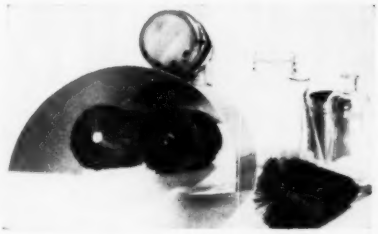

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A fundamental principle in construction planning is that function must be the primary consideration. This is especially important in hospital planning, inasmuch as the hospital's function is service. It has long been advocated that the hospital be planned in units of service and that these units then be grouped together. This principle is basic to all planning described in this volume. The flow of traffic in and out and from one of these units to another is an important element to function and therefore to planning, and it, too, has been given thorough consideration.

The book is logically divided into sections, each comprised of chapters. A section on "Design and Construction" early in the volume first describes clearly the necessary steps that should be taken to start on its way to fruition what is still only an idea in the mind of an individual or in the collective mind of the governing board. Both architect and hospital consultant are necessary even at this early stage, the latter to advise the former and to represent the governing board in an executive capacity during planning and construction. In selection of the site (to be done in consultation with both architect and hospital consultant) accessibility, public utilities, nuisances (noise, smoke, apparent fire hazards, both existent and future probabilities), orientation and exposure in various latitudes, cost, dimensions, topography and landscaping are fundamental factors to be considered and the discussion of these subjects brings together all current knowledge proved by experience. A useful feature is an "appraisal form for comparing sites for a hospital or health center" which should facilitate comparison of available sites. Only one example of the thoroughness of coverage is the inclusion of a warning that a site offered as a donation may, in the final analysis, be more costly than another apparently high cost plot.

A chapter on "The Building" contains a warning against first selecting a particular architectural appearance and then forcing the facilities into the plans. The reverse procedure is the proper one, inasmuch as the hospital is "a highly complicated, specialized functional structure which must be designed for the various facilities." The authors point out that a specific and detailed program of the hospital's requirements is therefore an essential prerequisite to planning. In this planning, discussion between administrator and department heads, consultant and architect plays an important part. From the more general discussion of the building, which includes a useful chart illustrating interior and exterior traffic flow, the authors proceed to a general discussion on circulation space (corridors, stairways, elevators).

Ensuing chapters, devoted to more detailed discussion of planning for specific departments and units, are translated into schematic plans in a later section of the book. Each chapter is illustrated with diagrams showing the flow of traffic within and through the department and tabular presentations to facilitate allotment of space for hospitals of 25, 50, 100, 150 and 200 bed capacity.

A comprehensive chapter on nursing facilities stresses the importance first of all of determining the "expected distribution" in order to make adequate area allotments. Studies have indicated normal distribution to be 40 to 60 per cent for surgical, 20 to 25 per cent for medical, 12 to 25 per cent for obstetrical, 10 per cent for pediatric other

than newborn, 9 to 15 per cent for miscellaneous patients (including eye, ear, nose and throat). Area allotments should also be made for bassinets, even though they are not included in the hospital bed count. A thorough general discussion of patient (or bed) areas is followed by a description of plans for one, two and four bed rooms, isolation unit, psychiatric room, treatment room, nurses' station, consultation room, utility room, floor pantry, solarium, visitors' room, flower room, toilet, bedpan and bathroom unit, closets and pediatric unit. As with all other chapters, this one is supplemented by a tabular presentation of patient-area needs, in square feet, in nursing departments of hospitals of 25, 50, 100, 150 and 200 beds, as well as by a chart showing the flow of traffic. Equally comprehensive are the sections in the same chapter devoted to psychiatric service and tuberculosis nursing units.

All other chapters are organized in the same logical manner. Chapters are included on administration, surgical facilities, obstetrical facilities, adjunct diagnostic and treatment facilities, emergency department, optional facilities (outpatient department, dental unit, health center, personnel housing, teaching facilities), service department (dietary, housekeeping, employes' facilities, storage, mechanical plant, and maintenance shops), mechanical facilities (heating and ventilating, kitchen, laundry and plumbing). Electrical facilities, elevators and dumb-waiters, the hospital structure, materials and finishes, fire safety, and factors that affect cost, all are discussed in separate chapters. The section ends with a chapter entitled "Programming, Planning, Construction and the Architect" in which is summarized the construction procedure through all the stages from preparing the program to equipping the building.

The section on "Elements of the General Hospital" contains 97 plans in which the material in the previous section is translated into schematic drawings. Plans are included for all units, largest to smallest, or hospitals of various sizes. Each plan is complete with equipment, both drawn in its place and listed in a legend. These plans should be of great practical use, not only for hospital consultants and architects, but as visual aids for boards of trustees, administrators and teachers and students of hospital administration.

A particularly useful chapter is entitled "Factors That Affect Costs," in which the traditional "cost per bed" method of estimating hospital construction is analyzed and a plea is made for a more realistic method of cost estimation.

Administrators and others whose responsibility it is to plan and purchase equipment for the new general hospital will be greatly aided by the chapter on this subject, in which the preparation of an equipment list is described in eight steps. The matter of cost is then simplified by means of charts, keyed to equipment lists for the separate units in various sized hospitals. Departmental equipment costs are also included. The 19 page equipment list, intended as a guide, should serve this purpose admirably.

Twelve area charts complete the text of this valuable volume. They suggest space assignments for various activities in a general hospital set up with service and accommodations for surgery, obstetrics, medicine, pediatrics and emergency care, in hospitals of 25, 50, 100, 150 and 200 bed capacity. The volume also includes a bibliography.
—MALCOLM T. MACEACHERN, M.D.

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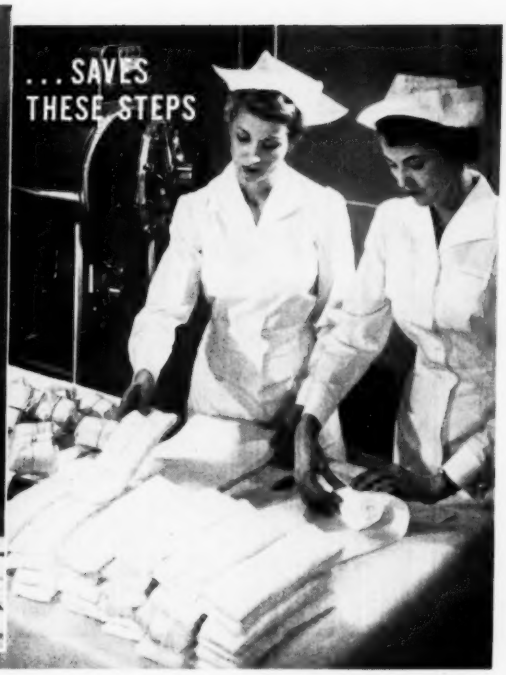

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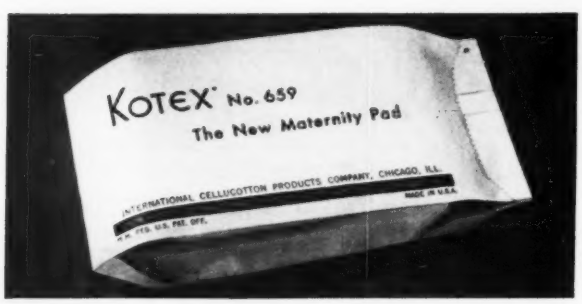
assure aseptic technic... save nurse time

- Individually packed in sealed bags, ready for sterilization
- Saves you costly hand labor and materials now spent in preparing pads for sterilization
- Provides safer aseptic perineal care: controls possibility of post partum infection
- *Convenient disposal bag* completes aseptic technic
- Bag design, and printed easy-to-follow instructions, help teach patients better perineal care
- Individual units make record-keeping easy; supplied 500 *Pre-Pack* pads per case
- Ask your *Curity* Representative about this new *Pre-Pack* maternity pad!



NEW

No. 659 KOTEX*

PRE-PACK

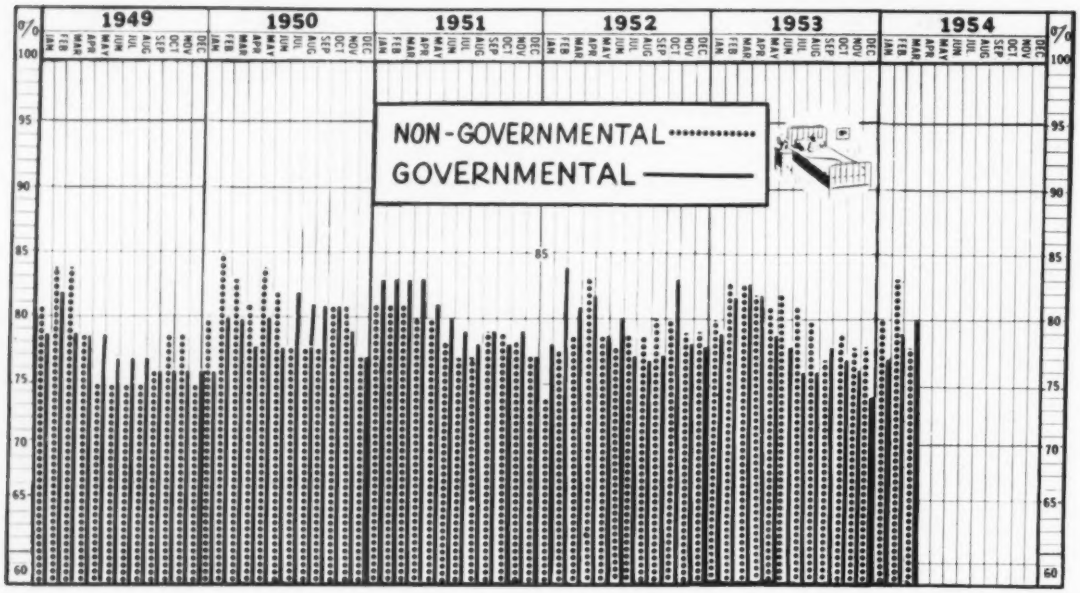
BAUER & BLACK

Division of The Kendall Company

309 West Jackson Boulevard
Chicago 6, Illinois

*T. M. Reg. U.S. Pat. Off. I. C. P. Co.

Construction Projects Total $158,266,782



Reports to the Occupancy Chart indicate that governmental hospitals were 80.1 per cent filled during the month of March, while nongovernmental hospitals were 78.3 per cent occupied. These compare to 80.8 per cent occupancy of governmental hospitals in March 1953, and 82.1 per cent in nongovernmental hospitals.

Construction for the period March 22 through April 5 totaled $51,360,050; for the same period in 1953, construction amounted to $43,341,032. Total construction in 1954 to date is $158,266,782; last year at this time the total was $279,025,717. Of 53 projects reported, 29 are new hospitals and 24 are additions.

LUBBOCK MEMORIAL HOSPITAL
Lubbock, Texas

Architect: Haynes & Kirby
Acoustical Contractor: Williams-Moore Co.

Exceptionally high in acoustical efficiency, the Arrestone ceiling in the kitchen is also incombustible. Installed by mechanical suspension, individual units of Arrestone can be readily removed for easy access to concealed pipes and wiring.

Cushiontone's low cost was another factor in its selection. Economical in installation and maintenance as well as in initial price, Cushiontone acoustical ceilings are often the choice where a strict budget must be considered.

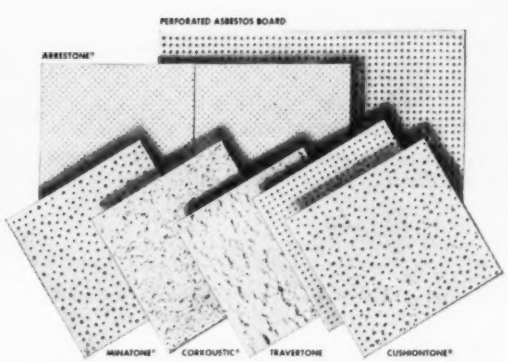
Hospital finds these noise-absorbing ceilings easy to clean

Only the highest sanitary standards can be accepted in a hospital. In selecting sound-conditioning materials for the Lubbock Memorial Hospital in Texas, ease of upkeep was as important as high acoustical efficiency. Both these requirements were met by choosing ceilings of Armstrong's Cushiontone and Armstrong's Arrestone.

Cushiontone was used throughout the corridors, offices, and cafeteria. It is a low-cost, efficient wood fiber tile with a neatly perforated, white painted surface. To meet sanitary requirements, Cushiontone can be washed or repainted whenever necessary without impairing its acoustical efficiency.

The kitchen required a material not only high in sound absorption but also offering easy maintenance and resistance to the deteriorating effects of steam Here, Armstrong's Arrestone — a perforated metal pan material backed up with mineral wool pads — was used.

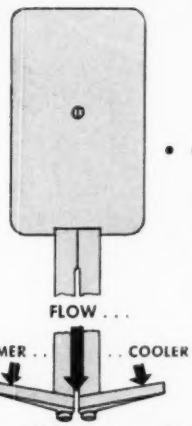
No one material can solve every sound-conditioning problem. That's why Armstrong offers a complete line of acoustical materials. For further details, see your Armstrong Acoustical Contractor, and for the free booklet, "How to Select an Acoustical Material," write Armstrong Cork Company, 4205 Union Street, Lancaster, Penna.



ARMSTRONG'S ACOUSTICAL MATERIALS

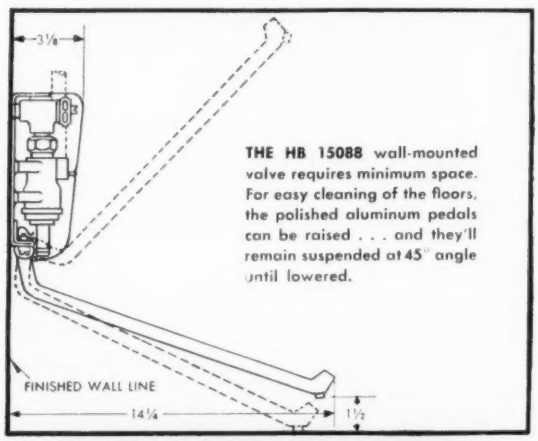
HF 12145 P vitreous china lavatory with HB 15088 pedal valve and type N tempered supply line. This valve is ideal for use with surgeons' scrub-up sinks and other lavatories, too.

Angled pedals permit one-foot control of water flow and water temperature



. . . with this new Double-Pedal Mixing Valve

without lifting your foot



THE HB 15088 wall-mounted valve requires minimum space. For easy cleaning of the floors, the polished aluminum pedals can be raised . . . and they'll remain suspended at 45° angle until lowered.

Angled pedals make this new wall-mounted, foot-operated valve more convenient to use. One foot controls both water flow and water temperature, leaving hands *completely* free.

With this new pedal design, the heel acts as a pivot. Light pressure on one pedal starts flow of hot water, pressure on the other a supply of cold water. An even down-pressure produces tepid water. You get maximum water flow with only 1½" pedal travel.

This new self-closing valve brings welcomed convenience to many fixtures. With a bedpan cleanser, for instance, it eliminates fussing with other valves. Water is controlled solely by the foot pedals. When pedals are released, water automatically shuts off . . . no pressure is left in the hose.

HF 13411 VP GLENCO TOILET is shown with HB 15334 foot valve bedpan cleanser assembly. Pedal valve can also be specified for other closets and clinic service sinks.

AMERICAN-Standard

American Radiator & Standard Sanitary Corporation, P. O. Box 1226, Pittsburgh 30, Penna.

Serving home and industry

AMERICAN-STANDARD · AMERICAN BLOWER · CHURCH SEATS & WALL TILE · DETROIT CONTROLS · KEWANEE BOILERS · ROSS EXCHANGERS · SUNBEAM AIR CONDITIONERS

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Ten per cent discount for two or more insertions without changes of copy. Forms close 15th of month.

POSITIONS WANTED

ASSISTANT ADMINISTRATOR—PURCHASING AGENT. Business administration major; 5½ years executive experience in business, 4 years medical and surgical purchasing, 2 years assistant administrator large hospital. Reply, MW 40, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—M.D.; female, 29; trained at outstanding center; four years experience; available June 15. Reply, MW 34, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

ANESTHETIST—M.D.; familiar all methods anesthesia; 7 years experience; seeks hospital appointment or group association; salary or percentage; now available. Reply, MW 38, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

DIETITIAN—Ten years experience; presently employed, midwest; seeks change, preferably Florida or west coast. Reply, MW 39, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

LIBRARIAN—Medical record; registered; experienced; competent organizer; college training; well qualified; work well with medical staff; employed. Reply, MW 41, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

STEWARD—Hospital food steward, fully trained in dietary management, buying, receiving, issuing of all foods and menu making; capable of installing selective menu for patients and cost accounting procedures for dietary operation; able to effect a substantial saving of dietary cost of operation and at the same time increase the quality of food service; desires position in hospital from 100 to 200 beds; available for interview immediately. Reply, MW 36, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

PALMOLIVE BUILDING **CHICAGO**

ADMINISTRATOR—Physician, well trained and well experienced; M.S., Hospital Administration; administrative internship and two years, assistant administrator, teaching hospital; five years, director, large teaching hospital.

ADMINISTRATOR—B.S., Nursing; M.B.A., Hospital Administration; three years, director of nurses, university hospital; six years, assistant administrator, 450-bed hospital.

ADMINISTRATOR—M.B.A., Hospital Administration; administrative residency and three years, assistant administrator, large teaching hospital; six years, director, 300-bed general hospital.

COMPTROLLER—B.S., Business Administration; six years, comptroller, 250-bed hospital.

PATHOLOGIST—Diplomate; three years, assistant professor of pathology, medical school and associate director, its teaching hospital; since 1947, director of pathology, 350-bed hospital.

MEDICAL BUREAU—*Continued*

PERSONNEL DIRECTOR—Seven years, personnel director in industry; four years, personnel director, 300-bed hospital.

RADIOLOGIST—Diplomate; M.D., Harvard; university hospital training in radiology; four years, associate radiologist, university hospital and medical school.

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Dey, Director
332 Bulkley Building
Cleveland, Ohio

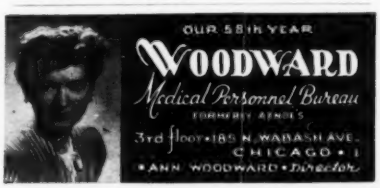
NURSE SUPERINTENDENT—Available August; 3 years, night superintendent, 150-bed hospital, New York; past 10 years, superintendent, 85-bed Ohio hospital; well qualified.

ADMINISTRATOR—Or business manager; 3 years, assistant administrator, 300-bed Pennsylvania hospital; 6 years, administrator, 120-bed hospital, east.

ASSISTANT ADMINISTRATOR—M.H.A. Degree, University of Chicago; 2 years, administrative resident and assistant, 350-bed hospital; any locality considered.

ASSISTANT ADMINISTRATOR—B.S. Degree, Hotel Administration, eastern university; 4 years, assistant manager, 300-bed unit of large midwestern teaching hospital; 2 years, personnel manager, industrial firm.

EXECUTIVE HOUSEKEEPER—B.S. Degree; 4 years, assistant housekeeper, teaching hospital; 3 years, executive housekeeper; desires change.



ADMINISTRATOR—M.B.A.; year's hospital residency; 4 years, assistant superintendent, university hospital, 500 beds; also director, 200-bed university maternity hospital; 3 years, director, general hospital, 300 beds; outstanding personality; early 40's; member, ACHA; immediately available.

ADMINISTRATOR—Medical; 10 years very successful commercial and sales administrative experience prior to Doctorate licensure; 4 years, medical director, important medical and hospital association; currently assistant director, one of most important teaching hospitals; early 40's; excellent clinical and administrative background.

ANESTHESIOLOGIST—Diplomate; trained university hospital; 3 years, director, anesthesiology, general hospital, 350 beds; 6 years, attendant anesthesiologist, several very important hospitals; seeks directorship, anesthesiology, full time, large hospital preferably east coast or New England; middle 40's; outstanding specialist.

DIRECTOR OF NURSES—B.S., M.A.; excellent experience includes several years, educational director, general hospital, 500 beds; 7 years, assistant chief, nursing education, public health coordinator and area consultant, important hospitals and United States Department of Interior; early 40's.

(Continued on page 188)

WOODWARD—*Continued*

EXECUTIVE HOUSEKEEPER—Outstanding, well-trained, experienced person; experience includes executive housekeeper, general hospitals, 500-750 beds; can recommend without reservation; NEHA; prefers warm climate; elderly.

EDUCATIONAL DIRECTOR—M.S., Education; M.S., Public Health; outstanding teacher; affiliated 8 years with national health organization; early 40's.

PATHOLOGIST—32; M.S., Pathology; Diplomate, pathologic anatomy, clinical pathology; 27 months, pathology, USAMC; finishing 4 years training, pathology, university hospital, including 3 years, Mayo Foundation.

RADIOLOGIST—34; Certified, diagnostic and therapy; experienced in cancer; 2 years, successful private practice and consultant, radiology, 3 hospitals; prefers Middle-Atlantic states; immediately available.

RADIOLOGIST—33; Certified both diagnostic, therapeutic; trained university hospital; 4 years, associate radiologist, 700-bed teaching hospital; now wishes head own department; any locality; very well trained and experienced man; outstanding references.

POSITIONS OPEN

ADMINISTRATOR—The Macon Hospital, which upon completion of its new beds, now building, will have a capacity of 550, announces a vacancy in the position of administrator. Interested applicants please communicate with the Macon Hospital Commission, Box 255, Macon, Georgia.

ANESTHETIST—Moving to Milwaukee? Position for nurse anesthetist in 350-bed teaching hospital with residents and interns; present staff of eight nurse anesthetists and three medical anesthetists; work averages 32 hours per week plus 24 hours additional on call; salary open; month's vacation with pay; other benefits. Apply to: Administrator, Milwaukee Hospital, 2200 West Kilbourn Avenue, Milwaukee 3, Wisconsin.

ANESTHETIST—Nurse; excellent opportunity, 150-bed general hospital. Write or phone, Dr. E. L. Close, Northeastern Hospital, Philadelphia 34, Pennsylvania.

ANESTHETIST—Nurse; for 250-bed general hospital; excellent working conditions and personnel policies; good starting salary. Write: Mr. Bert Stajich, Assistant Administrator, Columbia Hospital, 3321 North Maryland Avenue, Milwaukee 11, Wisconsin.

ANESTHETISTS—Nurse; for 150-bed general hospital; four nurses, full-time M.D., all agents and techniques; one month's vacation; two and one-half hours from Boston and New York. Write, G. J. Carroll, M.D., Chief of Anesthesia Department, William W. Backus Hospital, Norwich, Connecticut.

CAFETERIA MANAGER—Large, well-equipped pay cafeteria, $25,000 business per month; salary commensurate with responsibility; no Sunday work; three weeks vacation; pension and social security; apartments outside available at reasonable cost. Apply, Ella M. Eck, University of Chicago Clinics, 950 East 59th Street, Chicago 37, Illinois.

classified advertising

POSITIONS OPEN

DIETARY SERVICES—Director: applications are invited for this position, for a 500-bed medical teaching hospital; high administrative qualifications and broad knowledge required to the end that the most suitable system of food distribution can be incorporated in present major building program: salary open. Address applications to the Superintendent's Office, Kingston General Hospital, Kingston, Ontario, Canada.

DIETITIAN—A.D.A. member; 2 dietitians on the staff at the present time; good salary; 225-bed hospital, school of nursing; central food service. Contact Administrator, Riverside Hospitnl, Newport News, Virginin.

DIETITIAN—Teaching; A.D.A.; 329-bed hospital, 150 student nurses; previous hospital and teaching experience desirable; 40-hour week; paid vacation and sick leave; social security; salary open. Apply: Deaconess Hospital, Buffalo 8, New York.

DIETITIAN—Qualified dietitians on present staff enable choice of therapeutic or administrative duties for newcomer; opportunity to round out your experience; 242 beds, recently expanded; near Chicago. Methodist Hospital, Gary, Indiana.

DIETITIAN—For modern 75-bed hospital located in suburb of Montreal on Lake St. Louis; full maintenance provided. Apply, Administrator, Lachine General Hospital, Lachine, Quebec, Canada.

DIETITIAN—Required for 67-bed general hospital; good salary, favorable personnel policies. Apply, stating experience, to Superintendent, Portage la Prairie General Hospital, Portage la Prairie, Manitoba, Canada.

DIETITIANS — Therapeutic dietitians; Barnes Hospital, large teaching hospital; 3 units affiliated with Washington University School of Medicine; beginning salary $270 month; social security. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIANS—Openings for 2 A.D.A. dietitians; 40-hour week; free Blue Cross, excellent salary and life insurance, 3 weeks paid vacation, etc. Trumbull Memorial Hospital, Warren, Ohio.

DIRECTOR OF NURSING SERVICE—To organize and direct nursing service in 45-bed hospital; experience preferred; however, will consider career-minded person wishing to advance in field; 40-hour week with liberal benefits; salary commensurate with ability and experience; wih hire immediately. Apply, Administrator, Victory Memorial Hospital, Stanley, Wisconsin.

(Continued on page 190)

DIRECTOR OF NURSING—Starting salary $4964; also, assistant director of nursing, starting salary $4206; for state tuberculosis hospitals; minimum requirements for both positions include 30 earned college credits; two years in administrative capacity required for the director position; two years as supervisor or faculty member required for assistant director position; New York State residence not required. Apply, MO 82, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INSTRUCTOR—Clinical; teach medical and surgical nursing; approved school in 224-bed general hospital; one class admitted annually; qualifications—B.S. Degree, 2 years teaching experience or equivalent; excellent salary; regular increases; 40-hour week; vacations; sick leave. Write, Director of Nursing, St. Luke's Hospital, Newburgh, New York.

INSTRUCTOR—Clinical, in medical and surgical nursing; new position to assist in program for affiliating collegiate students; 300-bed hospital; 40-hour week; 4-week vacation; beginning salary $300; minimum requirement B.S. in Nursing Education; position open August 15. Apply to Director of Nursing, Highland Hospital, Rochester 20, New York.

INSTRUCTOR—Clinical; for medical-surgical floors in 110-bed general hospital; experience required, Degree in Nursing Education desirable; salary open. Apply, MO 83, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

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POSITIONS OPEN

INSTRUCTOR—Clinical, in obstetrics; 332-bed hospital located in an attractive residential section; student body of 160; Degree in Nursing Education and some teaching experience preferred; salary range for 40-hour week, $320-$430; beginning salary commensurate with experience and preparation; liberal personnel policies; living accommodations available. Apply to Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

INSTRUCTOR—Assistant, nursing arts; 300-bed general hospital; one class a year; B.S. and courses in education; beginning salary $275; good personnel policies including 40-hour week, 4-week vacation; position open August 15. Apply to Director of Nursing, Highland Hospital, Rochester 20, New York.

INSTRUCTOR—Of nursing; starting salary $3571; Civil service positions available in mental hygiene institutions at various locations; New York State residence not required; college credits required and experience in teaching or supervision; 4 weeks vacation, 12 days sick leave per year; annual salary raises, retirement system, educational leaves. Apply, MO 81, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

INSTRUCTOR—Science; for basic sciences; one class a year; 300-bed hospital; B.S. Degree with a major in Science; will accept male or female applicant; 40-hour week; 4-week vacation; beginning salary $325; position open August 15. Apply to Director of Nursing, Highland Hospital, Rochester 20, New York.

INSTRUCTOR—Science; approved school of nursing has excellent opportunity for qualified science instructor; fine, modern equipment; living accommodations available; salary open; pension plan; travel arrangements for interview. Apply to Personnel Director, The Christ Hospital, 2139 Auburn Avenue, Cincinnati, Ohio.

INSTRUCTOR—Science; teach anatomy and physiology, chemistry and microbiology; approved school in 224-bed general hospital; one class admitted annually; qualifications—B.S. Degree, 2 years teaching experience or equivalent; excellent salary; regular increases; 40-hour week; vacations; sick leave. Write, Director of Nursing, St. Luke's Hospital, Newburgh, New York.

INSTRUCTORS—Physiological and Biological science and Medical-surgical; modern school, 60-65 students; degree and teaching experience required; salary open; 40-hour week; personnel policies above average; congenial, pleasant working conditions; university town with direct railroad transportation to Chicago. Sister Mary Florence, Director of Nursing, Mercy Hospital, Champaign-Urbana, Illinois.

LIBRARIAN—Medical record, registered; maintenance available; 66-bed voluntary non-profit hospital. Apply, Eastern Long Island Hospital, Greenport, New York.

MISCELLANEOUS — Assistant director of nurses, Supervisors and Head nurses for 2200-bed psychiatric hospital; salary depends on experience and qualifications; additional Staff needed for Educational and Therapeutic programs. For particulars apply to Personnel Director, Central State Hospital, Indianapolis 22, Indiana.

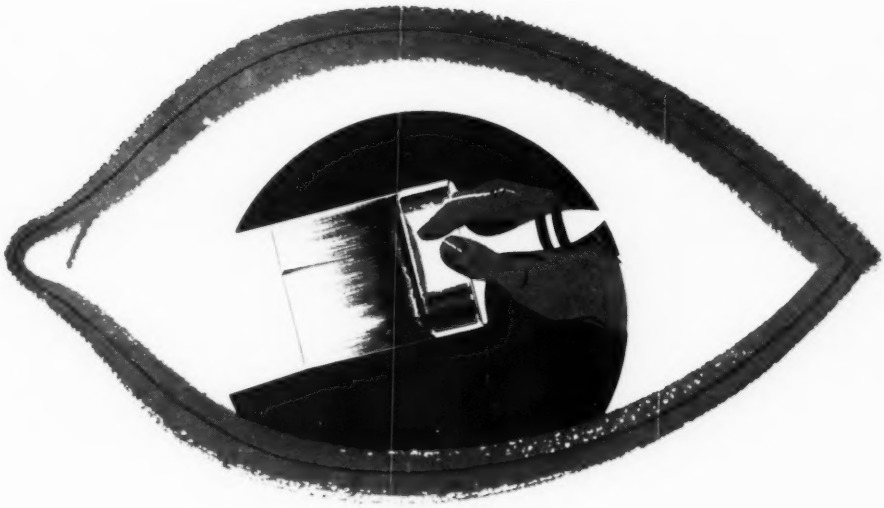
MISCELLANEOUS—Supervisors (2), Obstetrical and Surgical, General Duty Nurses at once; 34-bed hospital; separate residence, single rooms; salary includes full maintenance. Apply, Superintendent, Ajax and Pickering General Hospital, Ajax, Ontario, Canada.

NURSE—Head, nurseries; 60 bassinets; 225-bed general hospital, with new modern nurseries being planned; good salary to qualified person; 40-hour week. Apply, Director of Nursing, San Jose Hospital, San Jose, California.

NURSES—Assistant head nurses; registered; due to expanding facilities, openings available in all areas—surgical, medical, obstetrics, etc.; living accommodations available; paid benefits. Write Personnel Office, Jewish Hospital, Cincinnati 29, Ohio.

NURSES—Graduate; for hospital located near beautiful Lake George; salary with complete maintenance; $10 differential afternoon and night duty; 8-hour day, 5-day week; time-and-one-half for overtime. Moses-Ludington Hospital, Ticonderoga, New York.

(Continued on page 192)



If you're keeping your eye on **Painting Costs**

Take a Good Look at This

It's much too good to miss! It's the newest, most outstanding one-coat paint on the market . . . a paint that's high in quality and low in application costs, in keeping with Barreled Sunlight's fame.

It's truly odor-free. Easy to apply . . . by brush or spray or roller. And *one* fast-drying coat gives you a smooth, uniform solid-hiding paint surface that is washable and scrubbable . . . in fact *even scuff marks wipe right off.*

Yes, take a good look at Barreled Sunlight Odor-Free Alkyd Flat and Semi-Gloss Finishes . . . in white and many distinctive colors. You'll find that here is a paint that cuts hotel, hospital, school, office and other institutional and commercial painting costs in a revolutionary way.

Write for free color card and name of your nearest Barreled Sunlight distributor. Barreled Sunlight Paint Co., 30-E Dudley St., Providence 1, R. I.

Goes On Like A Breeze
Truly Odor-Free
Really Covers In One Coat
Outstanding Yardage
Fast Drying
Uniform Sheen & Color
Excellent Adhesion
Mar Resistant
Really Scrubbable

Barreled Sunlight® *Paints*

In whitest white or clean, clear, wanted colors, there's a Barreled Sunlight Paint for every job

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POSITIONS OPEN

NURSES—Graduate; for new 50-bed general hospital in thriving village, Catskill Mountains; 8-hour day, 6-day week, time-and-one-half for overtime after 40 hours, rotating shifts; average gross cash salary $200 to $210 month; full maintenance available for $10.50 week. Apply, Superintendent Nurses, Margaretville Hospital, Margaretville, New York. Phone Margaretville 50.

NURSES—Obstetric; staff, head nurse, and assistant supervisor; positions available in labor and delivery, post partum, newborn nursery and premature center; staff nurse salary range: $240 to $275 monthly; $17 bonus evening or night duty; liberal vacation and sick leave; social security and retirement plans; located in the heart of the beautiful Finger Lakes region; diverse educational, cultural and recreational facilities. Apply, Director of Nursing, Rochester General Hospital, Rochester 8, New York.

NURSES—Operating room and obstetrical; California hospital on San Francisco Bay; forty minutes from that city; 5-day week; salary $275 per month if applicant has advanced preparation or experience; $10 additional for evening and night duty; maintenance available. Director of Nursing, Alameda Hospital, Alameda, California.

NURSES—Operating room; 300-bed hospital; 40-hour week; all cash salary; special consideration for experience and advance preparation; bonus for "on call"; liberal personnel policies, including social security, plus a retirement plan. Apply, Director of Nursing, Mercer Hospital, Trenton 8, New Jersey.

NURSES—Psychiatric; for a new psychintric unit in a 700-bed hospital; excellent personnel policies. Write Mrs. Aileen L. Carroll, Director of Nursing, The Buffalo General Hospital, 100 High Street, Buffalo, New York.

NURSES—General staff; 250-bed general hospital and 72-bed maternity hospital; starting salary $280; $5 per month tenure increase for each six months of service to a maximum of $310; social security, sick leave, prepaid medical and hospital care; $10 additional for afternoon and night shift; $10 additional for delivery room; $20 additional for surgery; up to three weeks' vacation at end of 4 years; 7 paid holidays; 8-hour day, 40-hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, California.

NURSES—Registered, operating room; staff positions in 400-bed teaching hospital 25 minutes from Times Square; salary $260-$280 per month; 5-day, 40-hour week; 4 weeks vacation; 21 sick days; 7 holidays. Apply, Personnel Officer, The Brooklyn Hospital, 121 DeKalb Avenue, Brooklyn, New York.

PATHOLOGIST—To head department; approved hospital in Pennsylvania. Address reply to MO 80, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

SUPERVISOR—Assistant, evenings; 300-bed hospital; 40-hour week; 4-week vacation; beginning salary $300; minimum requirement B.S. in Nursing Education; position open May 1. Apply to Director of Nursing, Highland Hospital, Rochester 20, New York.

SUPERVISOR—Registered nurse; degree not necessary; responsibility of medical and surgical patient areas; supervision of graduate nurses and auxiliary personnel; salary dependent upon experience and ability; living accommodations available; 40-hour week, paid benefits. Write Personnel Office, The Jewish Hospital, Cincinnati 29, Ohio.

SUPERVISOR — Obstetrics; 300-bed general hospital; administrative and teaching responsibilities; B.S. and experience in teaching obstetrics; beginning salary $300; good personnel policies including 40-hour week, and 4-week vacation; position open September 1. Apply to Director of Nursing, Highland Hospital, Rochester 20, New York.

(Continued on page 193)

classified advertising

POSITIONS OPEN

SUPERVISOR—Administrative, operating room; 225-bed general hospital, with new modern surgeries being planned to meet immediate expansion program; top salary to qualified person; 40-hour week. Apply, Director of Nursing, San Jose Hospital, San Jose, California.

SUPERVISOR—Medical and surgical; 300-bed hospital; 40-hour week; 4-week vacation; beginning salary $300; minimum requirement B.S. in Nursing Education; position open May 1. Apply to Director of Nursing, Highland Hospital, Rochester, New York.

SUPERVISORS — Operating room supervisor and Assistant supervisor; salary open; complete maintenance if desired. Shriners' Hospital for Crippled Children, Philadelphia 15, Pennsylvania. MA 4-0700.

TECHNICIAN—Registered, experienced; for general laboratory work in a modern well-equipped 200-bed hospital; salary $325; 44-hour week. Department of Pathology, Port Huron Hospital, Port Huron, Michigan.

The Medical Bureau

M. BURNEICE LARSON—DIRECTOR

Telephone DElaware 7-1050

PALMOLIVE BUILDING — CHICAGO

ADMINISTRATORS—(a) One of country's leading hospitals operated by important university as its teaching hospital; preferably one who has demonstrated capacity to administer large hospital. (b) To succeed administrator retiring after 30-year tenure; voluntary general hospital, 375 beds; building program will increase facilities; university city, west. (c) Medical; new pediatric hospital, 200 beds, affiliated medical school; preferably one who can direct expansion program; challenging opportunity. (d) Assistant medical director; one of leading medical care programs; east. (e) Voluntary general hospital, 600 beds; college town, 60,000, east. (f) Voluntary general hospital, 300 beds; university city, south. (g) Assistant; 500-bed general hospital affiliated medical school; Master's degree, experience required; $6000-$7500; midwest. (h) Assistant; general hospital, 275 beds; Pacific coast. MH5—1

(Continued on page 194)

MEDICAL BUREAU—*Continued*

ADMINISTRATORS—NURSES. (a) Assistant; 400-bed general hospital; large city, medical center, midwest. (b) Administrator; convalescent hospital, 60 beds; residential town, near medical center, east; minimum, $5200, maintenance. (c) Assistant; 350-bed hospital, unit, university medical center; $6000-$7000. MH5—2

ANESTHETISTS—(a) Three; beautiful new 300-bed general hospital; college town, 125,000, southwest. (b) Modern general hospital, 100 beds; college town, midwest; $6000, maintenance. (c) Small general hospital; resort town on island off coast of Florida; $450, maintenance. MH5—3

COLLEGE, INDUSTRIAL, OFFICE—(a) Two infirmary nurses; New England. (b) Industrial nurse; Philadelphia. (c) Office nurse by prominent internist; university city. (d) Student health nurse; liberal arts college; mid-south. MH5—4

DIETITIANS—(a) Chief and assistant; 400-bed general hospital; college town, east. (b) Small general hospital; college town, southern California. (c) Food supervisors for two resident halls, small university; midwest. (d) Head; important teaching hospital; vicinity New York City. MH5—5

DIRECTORS OF NURSES—(a) Voluntary general hospital, 500 beds; school of outstanding reputation; teaching affiliations; college

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

town, 60,000, metropolitan area of East. (b) Voluntary general hospital, 410 beds; 170 students; departments well staffed; university city; midwest. (c) Psychiatric hospital; teaching program; outside United States. (d) Assistant; 475-bed general hospital; 170 students; interesting city; outside United States. (e) Director nursing service; university hospital, 300 beds; plans completed for new medical center which include hospital of considerably greater capacity. (f) Director of nursing service; new hospital, small size, for medical cases only; no chronic patients; California. MH5—6

EXECUTIVE HOUSEKEEPERS—(a) Municipal hospital, 2000 beds; $5600-$7100. (b) Small general hospital; resort city, west. MH5—7

EXECUTIVE PERSONNEL—(a) Chief comptroller; department staff of 25; 400-bed hospital; university city, midwest. (b) Chief engineer; degree, experience required; 300-bed general hospital; resort town, east. (c) Personnel director; general 550-bed hospital; 900 employees; east. (d) Purchasing director; university hospital, 500 beds; medical center, south. MH5—8

MEDICAL BUREAU—*Continued*

FACULTY POSTS—(a) Coordinator, centralized teaching program; collegiate affiliation; medical center; midwest; minimum $6000. (b) Educational director; fairly large general hospital; 170 students; interesting city, outside United States; mild climate. (c) Chairman, university nursing education department; qualified faculty in sciences, humanities, general education contribute to program; up to $9000. (d) Health instructor; duties include directing health program for student nurses at collegiate school; residential town, within commuting distance New York City. (e) Nursing arts and clinical in orthopedics and obstetrics; new hospital, 300 beds; Pacific coast. (f) Assistant professor in clinical instruction; university graduate nurse program; 10-month year; east. MH5—9

MEDICAL RECORD LIBRARIANS — (a) Chief, medical record section; new medical center; competent organizer required; $5000-$6500. (b) Chief; new hospital, general; 850 beds; medical school affiliations; resort city, south. MH5—10

SUPERVISORS—(a) Supervisors and head nurses for all departments; beautiful new hospital; unit, university group; opportunity continuing studies; large city, important medical center, west. (b) Operating room, new 350-bed hospital affiliated diagnostic clinic; staff of distinguished specialists; residential town, near several large cities, east; $5000. (c) Central supply; new department, small hospital; coastal town, California. (d) Floor; new

(Continued on page 195)

MEDICAL BUREAU—*Continued*

hospital; general; 200 beds; Florida. (e) Operating room and obstetrical; large general hospital, modern in every way; interesting city outside United States; mild pleasant climate. (f) Pediatric and medical clinic supervisors; new 300-bed general hospital; college town, $400. MH5—11

TECHNICIANS—(a) Chief technologist, biochemist, bacteriologist and general technologists; air-conditioned laboratory; new hospital; year-round resort city, Gulf Coast. (b) Chief x-ray technician; 700-bed teaching hospital; six technologists, 8 students; large city, medical center; midwest. (c) Physical therapist to take charge of department, large teaching hospital; medical center, south. (d) Histology technician; will consider general technician experienced tissue work; fine hospital; resort town, Florida. MH5—12

INTERSTATE MEDICAL PERSONNEL BUREAU

Miss Elsie Day, Director
332 Bulkley Building
Cleveland, Ohio

ADMINISTRATORS—(a) 300-bed general hospital, Ohio. (b) Small Ohio hospital; building program planned. (c) 200-bed Pennsylvania hospital.

classified advertising

POSITIONS OPEN

INTERSTATE—*Continued*

ASSISTANT ADMINISTRATORS—(a) 400-bed hospital, university city, midwest; $8000; open September. (b) Large organization, east; $10,000; accounting experience. (c) Home for aged; expansion program; $6000. (d) Office manager; 100-bed Ohio hospital.

BUSINESS MANAGERS—(a) 600-bed hospital, industrial city, east. (b) 50-bed hospital, central state; 30-bed addition planned. (c) 300-bed general hospital, northeast; modern institution; $6000; Accounting Degree preferred.

DIRECTORS, NURSING SERVICE—(a) 175-bed Ohio hospital. (b) 200-bed eastern hospital. (c) Sisters' hospital, new; 275 beds; midwest; $400. (d) 100-bed hospital, Virginia.

DIRECTORS, SCHOOLS OF NURSING—(a) Outstanding 300-bed hospital, east; $6500. (b) 300-bed Ohio hospital. (c) 200-bed midwestern hospital.

RECORD LIBRARIANS—(a) 125-bed Ohio hospital. (b) 140-bed Pennsylvania hospital. (c) Large hospital, east. (d) 100-bed California hospital.

TECHNICIANS—(a) Laboratory; to $350. (b) X-ray; chief; large university hospital, midwest. (c) Anesthetists; to $500, maintenance.

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

DIRECTORS OF NURSING—(a) West; 300-bed hospital; must have degree plus some administrative experience; $5000 plus maintenance. (b) West; 250-bed hospital in city of 45,000; school of nursing has approximately 80 students; $6000 to $7200. (c) Middle west; 250-bed hospital, fully approved, located in city of 90,000; $6000 plus maintenance. (d) East; 100-bed general hospital, fully approved; modern in all respects; ideal living facilities; $6000 plus maintenance. (e) East; 125-bed hospital; excellent nursing staff; 25-30 students in school of nursing; $6000 plus maintenance which includes a lovely apartment. (f) East; 300-bed hospital, fully approved; student enrollment 150; $6000 plus a nice apartment and maintenance.

DIETITIANS—(a) Head; east; 500-bed general hospital; supervise teaching program; 70 employees in department; $5000-$6000. (b) Head; northwest; 200-bed general hospital, fully approved; located in city of 40,000; 30

(Continued on page 196)

SHAY—*Continued*

in department. (c) Head; middle west; 225-bed general hospital located in a very progressive city; 2 large universities and splendid cultural and recreational facilities; $5000. (d) Assistant; middle west; 190-bed general hospital; must be qualified to handle special diets; 40 employees in department. (e) Head; south; 100-bed hospital; department is well staffed and has all latest and best equipment; new modern hospital located in pleasant college town; $4800. (f) Therapeutic; middle west; new, modern 300-bed hospital, fully approved; $3600.

MEDICAL TECHNOLOGISTS—(a) Middle west; 350-bed hospital affiliated with university medical school; requires some training in biochemistry as will supervise this phase of laboratory procedure; $6000. (b) Chief; south; 125-bed hospital; must be capable of teaching and have good administrative experience; $350-$450. (c) Chief; middle west; 100-bed hospital; ASCP or eligible with training in bacteriology and parasitology; four in laboratory; $375-$425. (d) Southwest; 250-bed hospital in large city; prefer experience or interest in hematology; $300. (e) East; 275-bed hospital located in city of about 175,000; good experience in all general clinical laboratory procedures; $350.

classified advertising

POSITIONS OPEN

ADMINISTRATORS—(a) Lay; voluntary general hospital, 230 beds; expansion program; one of finest in country; requires one with long experience and good educational background; to $18,000; will consider reimbursing travel expense; residential town 50,000 near important metropolis. (b) Medical; voluntary general hospital, 300 beds; requires one trained internal medicine; prefer with teaching experience; large city near important medical center; east. (c) Administrative director; lay; general hospital, 400 beds; expansion program; requires one with good educational background in hospital administration; large university city. (e) Lay; country's first fully approved hospital of physical medicine; important foundation hospital for crippled children; 140 beds; requires outstanding man. (f) Medical; general hospital, 175 beds; delightful resort city on ocean; California. (j) Lay; fully approved voluntary general hospital, 250 beds; recently opened; college town; southeast.

WOODWARD—*Continued*

ADMINISTRATORS—NURSES. (a) Voluntary general hospital, 90 beds; exceptionally well-equipped, including new physical therapy department; California. (e) General voluntary hospital, 50 beds; good financial condition; expansion plans; about $7000; lovely residential town; midwest. (f) Voluntary general hospital, 125 beds; outstanding woman required; $7-$10,000; east.

EXECUTIVE PERSONNEL—(a) Business manager; to develop into assistant administrator; requires accounting background; new hospital, 100 beds, near Chicago. (b) Business manager; group 10 diplomates; modern clinic building; large town near metropolis, California. (d) Comptroller; head accounting section; general hospital, 500 beds; large city; university medical center; midwest. (e) Personnel director; voluntary general hospital, 350 beds, in midst 200-bed expansion program; town 120,000; midwest; consider woman. (g) Purchasing agent; hospital experience; centralized purchasing; university medical school and its 500-bed hospital; will supervise department; southeast. (h) Purchasing agent; new general hospital, 260 beds; California.

INDIANA MEDICAL BUREAU
212 Bankers Trust Building
Indianapolis, Indiana

ADMINISTRATOR—High caliber man with proven record, for 200-bed eastern hospital; to $18,000.

INDIANA MEDICAL BUREAU—*Continued*

NURSE ANESTHETISTS—(a) 160-bed north-central hospital; $440 per month. (b) 600-bed midwestern hospital; 40 hours, no call. (c) 275-bed south-central hospital; 40 hours; no obstetrics.

DIRECTORS, OF NURSING AND SCHOOL—(a) 250-bed midwestern hospital; to $6000. (b) 200-bed midwestern hospital; salary open, quarters provided. (c) 250-bed midwestern hospital; $5000, quarters.

CHIEF ENGINEER—For 250-bed eastern hospital; includes supervision of housekeeping; salary from $6000.

REGISTERED PHARMACISTS—(a) Female; 300-bed midwestern hospital; salary open. (b) Female; 500-bed midwestern university hospital; salary open.

HOUSE PHYSICIAN—Small midwestern hospital; foreign doctor without license acceptable; $6000-$7500, if licensed, to $10,000.

PHYSICIAL THERAPISTS—(a) 300-bed midwestern hospital; orthopedic work; male or female; salary open. (b) Chief; 450-bed southwestern hospital, large orthopedic service; to $350.

RADIOLOGIST—60-bed western hospital, college town; salary open.

LABORATORY AND X-RAY TECHNICIAN—For 50-bed midwestern hospital; salary $350-$375.

(Continued on page 197)

classified advertising

PLACEMENT BUREAUS

MARY A. JOHNSON ASSOCIATES
11 West 42 Street New York 36, N. Y.
Mary A. Johnson, Ph.D., Director

FINE SCREENING BRINGS BEST RESULTS

Our careful study of positions and applicants produces maximum efficiency in selection. Candidates know that their credentials are carefully evaluated to individual situations, and only those who qualify are recommended. Our proven method shields both employer and applicant from needless interviews. We do not advertise specific available positions. Since it is our policy to make every effort to select the best candidate for the position and the best job for the candidate, we prefer to keep our listings strictly confidential.

We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee
Agency

THE MEDICAL FIELD
EMPLOYMENT AGENCY
790 Broad Street — cor. Market
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A MEDICAL AGENCY specializing in placements for Industry, Pharmaceutical Houses, Doctors' Offices and Institutional help.

Eleanor M. Mangini, R.N.
Director

BROWN'S MEDICAL BUREAU (Agency)
7 East 42nd Street
New York City 17

If you are seeking a position or personnel—please write. Gladys Brown, Owner-Director. We Do Not Charge a Registration Fee.

ZINSER PERSONNEL SERVICE
Anne V. Zinser, Director
Suite 1004—79 West Monroe Street
Chicago 3, Illinois

We have many good openings for Directors of Nurses, Instructors, Supervisors, Dietitians, Medical Technicians, Record Librarians and Staff Nurses. If you are looking for a position, please write us.

HOSPITAL PERSONNEL BUREAU
Charles J. Cotter, Director
(Licensed Employment Agent)
Professional Arts Bldg.
Hagerstown, Maryland
Telephones: Office—950; Res.—2885

Positions available, most areas. Administrators, Pathologists, Anesthetists, Pharmacists, Housekeepers, Technicians, Dietitians, Librarians, Directors of Nurses and all nursing positions. Send resumé, 10 snapshots, date available.

CALIFORNIA AND WEST COAST
Complete Coverage
Hospitals—Clinics
Excellent Openings—Confidential Services

CONTINENTAL MEDICAL BUREAU, Agency
510 West 6th Street, Los Angeles 14

PACIFIC COAST MEDICAL BUREAU
Agency
703 Market Street, San Francisco 3

(Continued on page 198)

classified advertising

FOR SALE

NURSES! ORDER THE NEW SEALED EDGE KENMORE NURSE'S KIT, "Your Pocket Pal." Save uniforms, save laundry bills, save time. Made of white box calf with three divisions for pen, surgical scissors and thermometer; also coin purse. THE PERFECT GIFT! $1 Postpaid. $7.50 per dozen. 8718 Ashcroft Ave., Hollywood 48, Calif.

New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

HARRY D. WELLS

400 East 59th Street, New York City

NURSING AND MEDICINE

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

OUTSTANDING REST HOME. Capacity operation. $850 per month net plus living, last quarter. Mild climate. Owner retiring.

AA REALTY

P. O. Box 621 Hamilton, Montana

MISCELLANEOUS

CLINICAL GROUP FORMING. Excellent location in central Los Angeles. Need several Staff M.D.'s. No investment required. H. C. Hoppe, 1601 Griffith Park Blvd., Los Angeles, California. Telephone—NOrmandy 14298.

SCHOOLS—SPECIAL INSTRUCTION

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $60 a month provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Mo.

SKIDMORE COLLEGE offers a one-semester program to graduate nurses in operating room nursing and unit management. For details write Chairman, Department of Nursing, Skidmore College, 303 E. 20th St., New York 3, N.Y.

Under his jacket

Are you proud that he has everything he needs as he starts the adventure of each day at school? Be prouder still of something hidden under his trim jacket —the stout heart that sends him off unafraid and eager.

This, too, you have given him because your love has made his small world secure. With it, he will build his own security as each challenge comes, in those days when he must stand alone without you.

What finer gift can you give those you love than the gift of security? It is the great privilege in America, where we are free to provide it.

And think, too—this is the way each of us helps build the security of our country, by simply taking care of our own. A secure America is the sum of its secure homes.

The security of *your* country begins in *your* home.

Saving for security is easy! Read every word—now!

If you've tried to save and failed, chances are it was because you didn't have a *plan*. Well, here's a savings system that really works—the Payroll Savings Plan for investing in U.S. Savings Bonds. This is all you do. Go to your company's pay office, choose the amount you want to save—a couple of dollars a payday, or as much as you wish. That money will be set aside for you before you even draw your pay. And automatically invested in Series "E" U.S. Savings Bonds which are turned over to you.

If you can save only $3.75 a week on the Plan, in 9 years and 8 months you will have $2,137.30.

U.S. Series "E" Bonds earn interest at an average of 3% per year, compounded semiannually, when held to maturity! And they can go on earning interest for as long as 19 years and 8 months if you wish, giving you a return of 80% on your original investment!

Eight million working men and women are building their security with the Payroll Savings Plan. For your sake, and your family's, too, how about signing up today? If you are self-employed, ask your banker about the Bond-A-Month Plan.

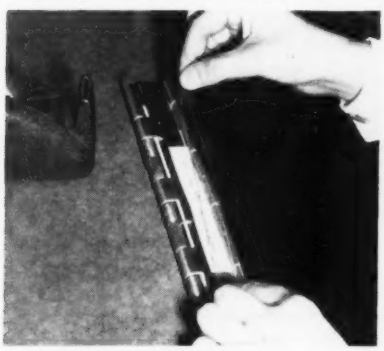
The U. S. Government does not pay for this advertisement. It is donated by this publication in cooperation with the Advertising Council and the Magazine Publishers of America.

DRESS MINOR SCRATCHES and lacerations with "Scotch" Cellophane Tape. It's less conspicuous, less irritating, less expensive . . . a welcome addition to every Outpatient Department.

SPECIAL INSTRUCTIONS are quickly attached to a patient's card file with "Scotch" Brand Tape. This thin, transparent tape holds perfectly, won't obliterate writing.

"These tape tricks speed up hospital routine"

Says Sister Eugene Marie, Administrator, Good Samaritan Hospital, Cincinnati, Ohio.



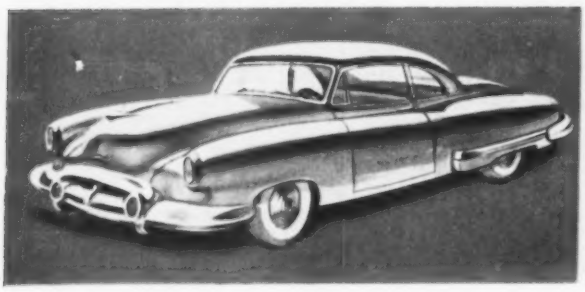
PATIENTS' CLIPBOARDS are easily labeled with the patient's name this simple way. Just write or type the name on a slip of paper, tape it to the board. "Scotch" Brand Tape does a neat, sanitary job.

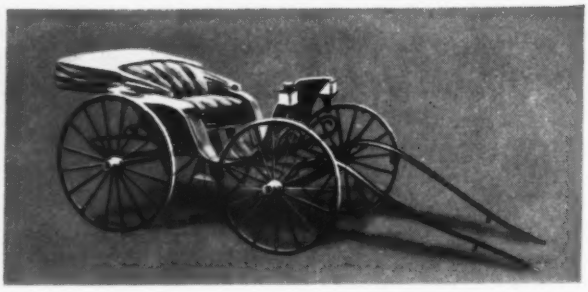
DUTY ROSTERS, check lists, special notices can be taped in prominent positions where they're sure to get attention. "Scotch" Cellophane Tape sticks at a touch, holds firmly, peels off clean.

"SCOTCH" CELLOPHANE TAPE simplifies all kinds of sealing, holding, mending jobs. Put a convenient "Scotch" Brand Dispenser on every floor . . . everyone has many uses for this tight-sticking tape.

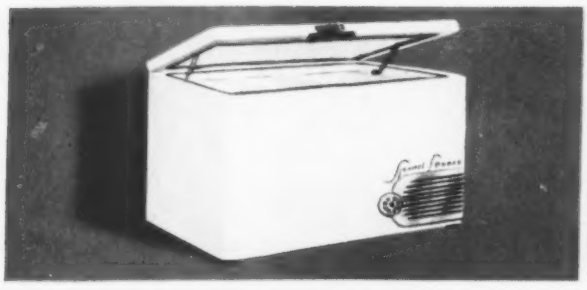
The term "Scotch" and the plaid design are registered trademarks of Minnesota Mining and Manufacturing Company, St. Paul 6, Minn.
General Export: 122 E. 42nd St., New York 17, N.Y. In Canada: London, Ont., Can.

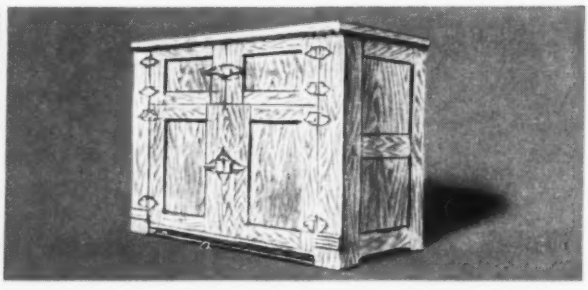
With the help of Advertising



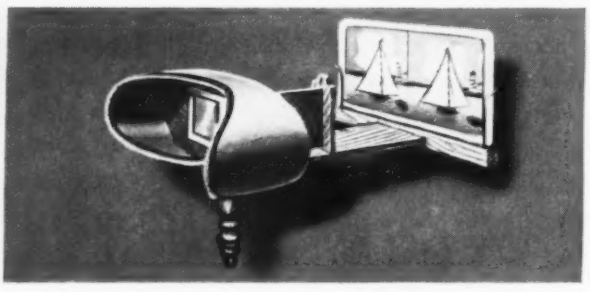


You have this . . . . . *Instead of this*





You have this . . . . . *Instead of this*



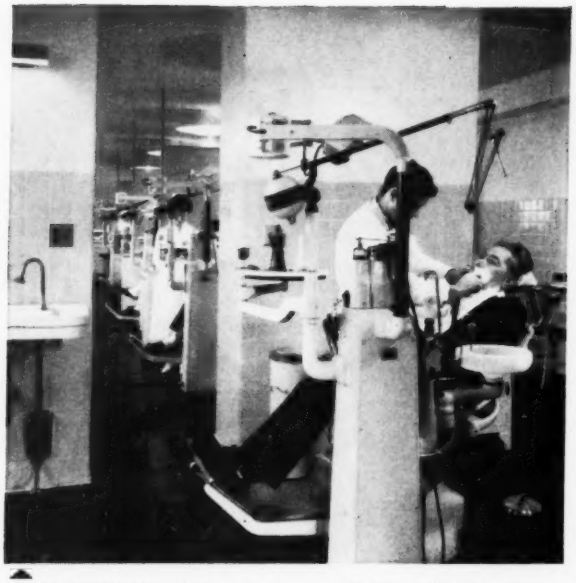
You have this . . . . . *Instead of this*

Advertising Benefits Everyone

The credit for the many wonderful products of our "American Way of Life" must be *divided*. The Inventor, the Investor, the Businessman, the Worker—all rightfully share that credit. **BUT** . . . it is *Advertising* that tells the story of the product; it is *Advertising* that whets public appetite for the product; and it is *Advertising* that helps sell the product. **AND** . . . the more product-demand that Advertising builds, the more products must be manufactured. That means Mass-Production which, in turn, means better products at lower prices. In short, a *still higher* American living standard. **SO** . . . *everyone* benefits. Industry, Business, Labor, Agriculture. But, most important of all, YOU the citizen.

And all with the help of Advertising!

ADVERTISING FEDERATION OF AMERICA *and* ADVERTISING ASSOCIATION OF THE WEST • *(Prepared by the Cleveland Advertising Club)*



Dental Department Mosaic 4¼" x 4¼" Glazed Tile wainscot.

Hydrotherapy Room Mosaic 1⅝" x 1⅝" Tile floor with walls of Mosaic 4¼" x 4¼" Glazed Tile.

Kitchen Walls and ceiling of Mosaic 4¼" x 4¼" Glazed Tile. Carlyle 6" x 6" Quarry Tile floor . . . a product of Mosaic.

Mosaic Clay Tile maintains high sanitation, at low cost, in **Ft. Hamilton V. A. Hospital,** *Brooklyn, N. Y.*

This "last-word" hospital makes wide use of the safety, sanitation, beauty and permanence properties of Mosaic Clay Tile. Throughout this building you'll find easy-to-clean, in-to-stay tile floors and walls. It's tile in operating suites, dental wards, kitchens, toilet and utility rooms . . . in all areas which require highest sanitation at low cost.

The outstanding new hospital material, highly regarded by Hospital Administrators and Planners, is Mosaic Impervious Electrically-Conductive Ceramic Mosaic Floor Tile! This remarkable tile, in surgical and anesthetizing areas, dissipates static electricity and prevents accumulation of dangerous electrostatic charges by providing moderate electrical conductivity for all personnel and equipment in contact with the floor. It's a *permanent* material, easy to maintain. And, its neutral warm brown color has a restful low light-reflecting factor. Every shipment fully covered by Warranty.

Learn all about Mosaic Clay Tile before you plan to build or modernize. Consult your Architect, Builder, Tile Contractor or write Dept. 49-2, The Mosaic Tile Company, Zanesville, Ohio for helpful information.

Skidmore, Owings & Merrill
Architects & Engineers
Tile Crafts Company, Inc.
Tile Contractors
Photos: Martin Helfer

For Free Estimates on (MOSAIC) Tile, see your phone book for the name of Your Tile Contractor (Ceramic)

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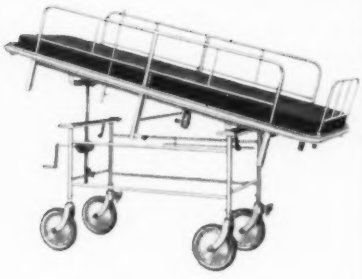
Offices, Showrooms and Warehouses across the Nation
Over 4000 Tile Contractors to serve you

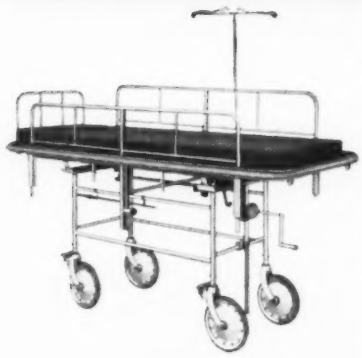
OFFICES: Atlanta - Baltimore - Boston - Buffalo - Chicago - Dallas - Denver - Detroit - Fresno - Greensboro - Hartford - Hempstead, L. I., N. Y. - Hollywood - Little Rock - Miami - Milwaukee Minneapolis - New Orleans - New York - Philadelphia - Pittsburgh - Portland - Rosemead, Cal. - Salt Lake City - San Antonio - San Francisco - Seattle - St. Louis - Tampa - Washington, D.C. - Zanesville

One takes care of 8 to 12 Post-Operative Cases

with the New Colson® *Post-Anesthesia Stretcher*



Colson Model 6868 Post-Anesthesia Stretcher with litter raised to shock position. Elevating device automatically locks itself at any position up to 20" e.evation. 10" ball-bearing casters lock to assure stability.



Colson Model 6868 Post-Anesthesia Stretcher ready to receive patient from operating table. Adjustable side rails raise to 13½" above 80" long litter; stand for fluid injections raises to 68".

• More and more progressive hospitals are adopting the modern procedure of post-anesthesia recovery rooms. Here patients are under the supervision of experts in post-operative care-with blood pressure units, gas tank and suction pump at hand in case of emergency.

One nurse can now take care of 8 to 12 post-anesthesia patients—a substantial savings in time, money and labor.

Latest thing in post-operative care, new Colson Post-Anesthesia Stretchers are of sturdy tubular construction, easy to keep clean and easy to operate. They are fully equipped to provide the utmost in safe, comfortable and convenient care of post-operative patients.

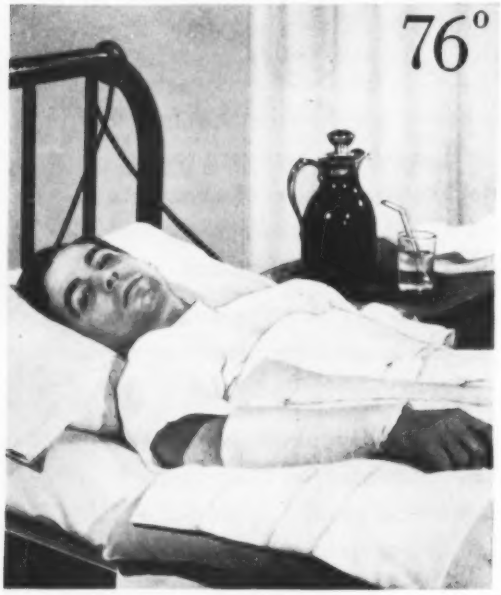
THE COLSON CORPORATION

ELYRIA, OHIO

WHEEL CHAIRS • WHEEL STRETCHERS • INHALATORS • TRAY TRUCKS • CASTERS • INSTRUMENT TABLES • FOOD CONVEYORS

Modern hospitals aid patient recovery with a thermostat in every room

In room 208, this patient is convalescing after an appendectomy. Her doctor felt that to help speed her recovery, a room temperature of 70° was best—possible *only* with Individual Room Temperature Control.



In room 308, this patient is recovering from post-accident shock, and his physician prescribed a temperature of 76°. This can be accurately maintained because the hospital has Honeywell Individual Room Thermostats.

PHYSICIANS and surgeons in many modern hospitals today can prescribe *exactly correct* room temperatures to help speed patient recovery. But this medical practice is possible *only when you have a thermostat in every room!*

That's why modern hospitals install Honeywell Individual Room Temperature Control. No other method can compensate for the varying effects of wind, sun, open windows, and other temperature factors in each room.

You'll want to investigate Individual Room Temperature Control if you plan to modernize your hospital or build a new one. Of course, the most economical time to install this system is when the hospital is being built . . . installations usually cost only between ½ and 1% of the expenditure per bed. And new methods make installations in existing hospitals practical, too.

For complete details on Honeywell Controls for your hospital, call your local Honeywell office . . . or write Honeywell, Dept. MH-5-78, 351 East Ohio Street, Chicago 11, Illinois.

Mark of a modern hospital!

You get all these features *only* in this specially designed Honeywell Hospital Thermostat:

- ***"Nite-Glowing dials"*** permit inspection without disturbing patients.
- ***New Speed-Set control knob*** is camouflaged against tampering.
- ***Lint-Seal*** insures trouble-free, dependable operation.
- ***Air-operated;*** requires no electrical connections.
- ***Magnified numerals*** make readings easy to see.

MINNEAPOLIS **Honeywell**

H HONEYWELL

First in Controls

112 OFFICES ACROSS THE NATION

What's New for Hospitals

MAY 1954 Edited by BESSIE COVERT

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 252. Check the numbers, on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Bedside Unit Combines Overbed Table

The Gammill Table Bedside Unit combines the advantages of a bedside cabinet and an overbed table. It was designed with the assistance of Lee C. Gammill, Director, St. Luke's Hospital and Texas Children's Hospital, Houston, Texas. The one compact unit puts all bedside necessities within easy reach of the patient, relieving nurses of details that the patient can handle for himself. The entire unit is easily adjustable to convenient height by either the patient or the nurse. Hence it is especially effective for use with variable height beds.

Space is saved by the campact unit which has two way door and drawer openings for convenience, built-in vanity compartment with mirror, and is easily moved on large casters. **Hill-Rom Company, Inc., Batesville, Ind.**

For more details circle #294 on mailing card.

Generator Series Powered by Chrysler Engines

A new series of complete, packaged electric power generating plants has been developed, with power supplied by Chrysler industrial engines. Designed to deliver full rated power with maximum efficiency and economy, the new Ready-Power generator series includes 50, 30 and 20 KW ratings. They are designed for either standby or continuous service and can be equipped for fully automatic emergency standby service in the hospital. The units are economical in fuel consumption and smooth and quiet in operation. The heavy welded structural steel base assures easy installation and permanent alignment without a special foundation. Controls for both engine and generator are located in a single, simplified control cabinet. **Ready-Power Company, 11231 Freud Ave., Detroit 14., Mich.**

For more details circle #295 on mailing card.

Selective Hold-Open for Rixson Door Closers

A selective hold-open mechanism can now be built into Rixson floor type, heavy duty door closers. The degree of hold-open is set at the factory to function at any point specified. When the "selector lever," easily accessible on the floor plate or threshold, is set, it places the automatic hold-open mechanism in contact position to hold the door when-

ever it is opened to the hold-open setting. A firm pull releases the door. The automatic hold-open does not function when the lever is set at non-contact position and the door closer functions normally, bringing the door to a quiet, gentle close. The selective hold-open can also be used in keeping doors open during warm weather. **The Oscar C. Rixson Company, 4452 W. Carroll Ave., Chicago 22.**

For more details circle #296 on mailing card.

Small Nipple for Premature Infants

The new Petite Nipple has been especially developed to fill the need for use with premature infants. It is suited to the large-mouth bottle and is completely interchangeable with the regular Seamless Eveready nipples. The new nipple is available either with cross-cut incision or regularly punched. **The Seamless Rubber Company, New Haven 3, Conn.**

For more details circle #297 on mailing card.

(Continued on page 212)

Thermotic Thoracic Pump for Lung Therapy

Developed as a result of three years of research, and designed to meet the rigid requirements of chest surgeons, the new Gomco Thermotic Thoracic Pump helps solve the problem of lung therapy following thoracic surgery. It accomplishes re-inflation by application of gentle, steady, intra-pleural suction, or negative pressure. The lowered pressure around the outside of the lung components prevents collapse.

Suction of the pump is easily regulated between safe limits to avoid hemorrhage and volume is high enough to take care of cases where leakage is present. The pump operates on the principle of expansion and contraction of air under temperature variations, with a timing mechanism to smooth out the suction. There are no moving parts and the action is silent. **Gomco Surgical Manufacturing Corp., 840-H E. Ferry St., Buffalo 11, N.Y.**

For more details circle #298 on mailing card.

Bed Pan Cover Is Disposable

A specially embossed cellulose material that drapes the bed pan completely and clings to it like cloth is used in the new Ipco Pan-Drape. Laundry is saved since this low cost bed pan cover is highly absorbent and is readily flushed away in the toilet or the bed pan washer-sterilizer. Pan-Drapes are dispensed from a specially designed stainless steel container that rests on a shelf or can be easily mounted on a tile wall. They are

easily and quickly handled, give effective coverage, and are economically priced. **Institutional Products Corp., 161 Sixth Ave., New York 13.**

For more details circle #299 on mailing card.

What's New . . .

Super Cloth Material for Institutional Garments

A strong, heavy weight material known as Super Cloth has been developed for use in institutional garments. It is available in made up garments or in yard goods, in a number of interesting patterns and bright cheerful colors. The material is woven to provide extra strength for use in garments for patients in custodial institutions who are destructive or who use force to try to remove the garments, yet it is soft in texture, smooth and comfortable. It is easily laundered, does not shrink, and can be ironed without difficulty. The fast-dye colors resist fading from exposure to strong light and from laundering.

Garments made of Super Cloth include dresses, pantie-dress combinations, pants, long and short sleeved shirts, and shorts, in sizes for children and adults. Careful research into the quality of garments required for patients in custodial institutions has resulted in Karoll-made garments of Super Cloth. Dresses are made in slip-over design with elasticized waistline. The designs have been worked out so that garments present the least possible opportunity for destruction to patients with destructive or immodest tendencies. All seams are double sewed with even-tension lockstitch with all stress points extra-reenforced with heavy bar-tacking.

The new dresses are available in a full range of sizes and all garments are made without buttons or ties. They are attractive and cheerful in appearance and comfortable to wear, thus improving morale among patients. They give extra long wear and are easy to maintain in a neat, clean condition. The extra strong garments would also give superior wear for ambulatory patients in chronic disease or other long stay hospitals not of a custodial character. The material would give long service in uniforms for housekeeping maids and other personnel where long wear is important and a cheerful appearance is an advantage. **Karoll's, Inc., Institution Div., 32 N. State St., Chicago 2.**

For more details circle #300 on mailing card.

Mattress Pad Is Comfortable and Practical

A seamless, one piece mattress pad that is soft and comfortable is offered in the new Bates Colonial. Made of fully bleached new white cotton, the pad has no filling or cross stitching to pull out. It clings to the mattress and holds the sheet, is light in weight and not bulky. Bias bound on all four sides, the mattress pad is easy to handle, launders and dries easily, takes a minimum of storage space and does not shrink in width. It can be washed in water of any temperature and is serviceable and economical. The pads are available in sizes 17 by 18 inches, 26 by 34 inches, 38 by 72 inches, 38 by 76 inches and 52 by 76 inches. **Bates Fabrics, Inc., 80 Worth St., New York 13.**

For more details circle #301 on mailing card.

Mopping Tank Has Improved Construction

Several improvements in the White Mopping Tank have resulted in a completely streamlined model with long life. The chassis is all steel welded construction. The plate type, ball bearing wheels

are cadmium plated and mounted under the center of the load for easier maneuverability and added strength. The self-cleaning water draw-offs are of solid bronze construction and do not drip or leak. The two compartments have a perforated plate in the bottom to catch the dirt. The truck is solidly constructed for long use and all parts are designed for efficient, easy operation. **White Mop Wringer Co., Fultonville, N.Y.**

For more details circle #302 on mailing card.

Cellulose Dinner Napkins Are Soft Yet Strong

A new 3 ply Dinner Napkin has been added to the Supersoft line. The napkin is made with new Cellostrength, a new, improved wetstrength with great absorbency. The addition makes Supersoft napkins now available in 2 ply, 3 ply and 4 ply wetstrength, providing attractive and durable paper napkins in varying weights which approximate fabric in feel, appearance and service, yet are expendable and thus save on laundry. **Groff Paper Co., 2300 Endicott St., St. Paul, Minn.**

For more details circle #303 on mailing card.

(Continued on page 216)

Liquid Chemical Cuts Time for X-Ray Film Processing

Fixer-Neutralizer is the name given to a new liquid chemical which speeds x-ray film processing and saves approximately 50 per cent in time. The chemical is used following the fixing process so that films do not become over fixed, and has been thoroughly tested. It also preserves films so that they may be kept for many years without danger of staining. Washing time is materially decreased when the new chemical is used, as is the overall processing time. **General Electric, X-Ray Department, 4855 Electric Ave., Milwaukee 1, Wis.**

For more details circle #304 on mailing card.

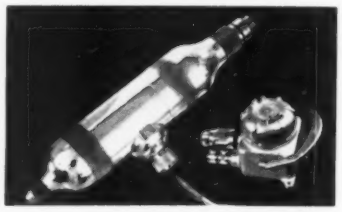
Light Weight Step Stands of Aluminum

A complete line of step stands is now available, fabricated from aluminum. These light weight stands are completely welded, are available with or without handrails, and are available in sizes from one to twelve steps with a 10 inch top platform. They are constructed of high alloy aluminum tubing and expanded metal and are impervious to rust, discoloration, acids and alkalis. When weight is placed on the stand the rubber tips grip the floor, preventing rolling when in use. When weight is removed, the self-locking casters are released and ready for rolling. **Scaffold Equipment Co., P.O. Box 8786, Pittsburgh 21, Pa.**

For more details circle #305 on mailing card.

Surgical Saw Is Explosion-Proof

A new electric bone saw has been developed as the result of many months of research and development. It is a fully explosion-proof unit which conforms to the safety requirements for Class 1, Group C, Hazardous Locations. The new Bishop Surgical Saw and foot switch is both oscillating and rotating. It retains all the advantages of the original Orthopedic Electric Bone Saw but is now approved by Underwriters Laboratories, according to the manufacturer, for use in locations containing highly combustible anesthetic agents. All blades, attachments and accessories used with the original Ortho-



pedic Electric Bone Saw are interchangeable and usable on the new explosion-proof unit. **Orthopedic Equipment Company, Bourbon, Ind.**

For more details circle #306 on mailing card.

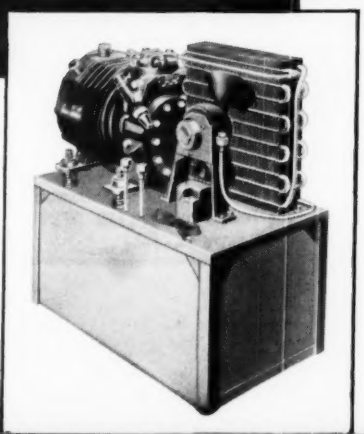
Another example of how **CRANE** plumbing fits modern hospital planning

Crane's specialized hospital plumbing is well-known not only for its durability and quality, but also for its advanced design that makes the best use of space. And Crane's new Coolbrook drinking fountain with Wal-Pak cooling unit is an outstanding example.

This new fountain illustrated at left, features semi-recessed wall installation for space-saving convenience and unobstructed corridors... for easier cleaning and maintenance.

And for chilling the water, the new economical Wal-Pak cooling unit is installed out of sight and out of the way inside the wall below the fountain. Costs no more than ordinary exposed water coolers, yet serves either one or two fountains on the same or adjacent floors with refreshing chilled water.

Your nearby Crane Branch or Crane Wholesaler can give you the full details on the whole line of efficient, economical Crane drinking fountains and other specialized hospital fixtures.



Compact Wal-Pak water cooling unit may be installed in a nearby closet or basement as well as directly under the fountain. Operates noiselessly, is tamper-proof, and economical. Easy to install in existing buildings without expensive changes or remodeling.

CRANE CO.

GENERAL OFFICES: 836 SOUTH MICHIGAN AVE., CHICAGO 5

VALVES . . . FITTINGS . . . PIPE . . . PLUMBING AND HEATING

instantly soluble PREAM® in packets

cuts coffee creaming costs!

PREAM PACKETS cost less per serving than cream! Hospitals save time, money, labor on regular meal costs and "off hour" coffee service. No creamers to wash. No spillage. No breakage. Re-use returns.

Dieticians acclaim delicious PREAM . . . a 100% pure dairy product. Powdered, in individual packets, it's instantly soluble . . . the sanitary way to serve creamed coffee with positive portion control.

No wasted unused portions, no spoilage . . . PREAM stays fresh indefinitely without refrigeration. Patients prefer nationally advertised PREAM. Add money-saving PREAM PACKETS to your next order.

SEND COUPON FOR SAMPLES

M & R DIETETIC LABORATORIES, INC.

COLUMBUS 16, OHIO

Please send samples of Pream Packets.

NAME_____

HOSPITAL_____

ADDRESS_____

CITY_____

Just 9 of 50,000 Items . . .

. . . used daily in every well-run kitchen are shown above as examples of the food preparation and service equipment sold by DON. Your DON salesman can show a lot more that will help you do more . . . with less work, less waste and in less time. On all the 50,000 Items, satisfaction guaranteed or your money back.

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1400 N. Miami Ave. Miami 32

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Stimulate FUND RAISING

Style B

Solid cast bronze or aluminum tablet. Raised letters in bold relief contrasting with stippled oxidized background.

Style P

Raised letter cast bronze room plaque with double line border. Available in all sizes.

Plaques & nameplates in bronze, aluminum or plastic have been proved the ideal, dignified and most effective way to raise funds for hospitals.

By acknowledging contributions in this permanent manner you encourage future donors. Why not write us now for illustrations and prices. You'll be pleased by this economical and attractive way to give permanent recognition.

A FEW OF OUR MANY HOSPITAL ACCOUNTS*

*Baton Rouge Hospital
*Cerebral Palsy Hospital
*Anderson County Hospital
*Kinga Daughters Hospital
*Mt. Sinai Hospital
*Sloan Kettering Institute

*Exact addresses furnished on request

"BRONZE TABLET HEADQUARTERS"

UNITED STATES BRONZE SIGN CO., INC.

570 Broadway Dept. MH New York 12, N. Y.

Reducing Diets? PRUNES BELONG!

Prunes add the variety and taste appeal that make low-calorie diets more appetizing. And their natural fruit sugar supplies the extra energy which dieters need. Yet prunes do *not* add extra calories.

Equally important, nutritious California Prunes provide a rich supply of essential vitamins (A and B_2) and minerals (iron, copper, calcium, prosphorous)—so necessary in *any* diet.

350 calorie BREAKFAST

When you're on a low-calorie diet, you won't feel you're skimping if you start the day with a hearty, healthy breakfast like this.

4 California Prunes with juice
(cooked without sugar)
Baked egg — 2 strips crisp bacon
Thin slice whole wheat toast
½ pat butter
Black coffee or tea

325 calorie LUNCH

Small glass tomato juice
Prune and peanut butter sandwich
on whole wheat bread
3-4 Celery sticks
Glass skim milk

PRUNE AND PEANUT BUTTER SPREAD

Combine ½ Tbsp. peanut butter, 2 chopped, pitted California Prunes, and ½ tsp. lemon juice. Mix to spreading consistency.

490 calorie DINNER

1 cup hot consommé
Medium-size serving pot roast
(no gravy)
Baked potato, ½ pat butter
Cole slaw with vinegar dressing
Prune Sherbet
Black coffee or tea

PRUNE SHERBET

Puree 8 pitted California Prunes, cooked without sugar. Dissolve 2 Tbsps. dry skim milk in ½ cup water; combine prunes, milk, and ¼ cup prune juice. Stir in 1 tsp. non-caloric liquid sweetener and 2 Tbsps. lemon juice. Freeze until mushy. Beat 2 egg whites until they form soft peaks. Blend into sherbet and re-freeze until firm. Makes 6 servings of approximately 45 calories each.

TABLE OF FRUIT EXCHANGES

(based on *Food Values of Portions Commonly Used*, Bowes and Church, 7th Ed., 1951)

4 medium-sized prunes, cooked without sugar, total about 86 calories — approximately the same calorie count as these other fruit servings:

1 med.-size raw apple	½ med.-size grapefruit
4-5 med.-size apricots	1 med.-size orange
1 small banana	1 cup sliced peaches

1 large slice canned pineapple

FOR FREE FORMULA BOOK of quantity recipes featuring California Prunes, send card to California Prune Marketing Program, 2 Pine Street, San Francisco, California.

include the California Wonder Fruit

PRUNES

✓ HIGH IN VITAMINS
✓ HIGH IN MINERALS
✓ HIGH IN ENERGY

What's New . . .

Rubber Bumpers for Movable Equipment

A new line of angle, strip and doughnut bumpers has been introduced for application to all types of movable equipment. The specially compounded rubber from which they are molded combines abrasive-resistance with shock absorbing resiliency. The bumpers have been made to give adequate protection to all surfaces that may be contacted, such as doors, corners, walls, furniture and other pieces of equipment. Each type of bumper is easily installed on either wood or metal equipment. Standard color is neutral green although other colors are available on order. A flexible steel insert is molded into the rubber for added strength. **Darnell Corporation, Ltd., 12000 Woodruff Ave., Downey, Calif.**

For more details circle #307 on mailing card.

Latex Resin Paint Covers Problem Surfaces

Latex and resin have been combined in the new formula for Luminall Stipple Texture Paint. It has been developed to transform old, cracked, uneven walls or ceilings into interiors free of plaster cracks, nailholes and other blemishes. It can also be used as an economical finish for dry-wall construction, concrete, brick, painted wood and metal. The coating plasters and paints in one operation, requiring no primer, sealer or undercoat. The paint is tough and resilient and can be washed two weeks after application.

The new paint is supplied in a concentrated form in a neutral shade for mixing with Satin Luminall Latex Paint for a variety of shades. The surface dries quickly, leaving no unpleasant odors or toxic fumes. **Luminall Paints, 3617 S. May St., Chicago 9.**

For more details circle #308 on mailing card.

Plastic Tube For Oxygen Connection

The new Pharmaseal® K-25 Oxygen Connecting Tube is a plastic tube designed for use in connecting the oxygen regulator to the oxygen administering equipment. It is made of long-lasting green plastic tubing which does not react to oxygen and does not deteriorate even during extended periods of use. Each end of the five foot tube is equipped with flexible connectors to fit all standard regulator sizes. The tube is light in weight so that it does not pull on the oxygen administering equipment. The distinctive green color identifies the tube for use with oxygen administration. It is designed for long use and is economical in price. **Pharmaseal Laboratories, Glendale 1, Calif.**

For more details circle #309 on mailing card.

Parking System Operates Without Attendants

An electrically operated parking system has been developed which provides controlled parking 24 hours a day, without attendant. The Parcoa system, developed by Johnson Fare Box Company, can be used for private parking for doctors and hospital personnel. It can also be set up for public parking for visitors' cars where space is available, thus providing a source of income to the hospital.

The system employs a coded card-key which actuates the control mechanism to operate the entrance and exit gates automatically. Only authorized card-key holders can park and the card-key can

be altered as required in revenue-producing parking areas where periodic charges are made, such as a monthly fee. The system operates without attendants, thus offering a saving in labor, while at the same time ensuring use of the parking area only by authorized individuals. It has a low first cost, requires minimum maintenance and provides complete safety. **Parking Corporation of America, 33 N. La Salle St., Chicago 2.**

For more details circle #310 on mailing card.

X-Ray Illuminator Has Stainless Steel Film Holder

The new Halsey Economy Instant Grip Illuminator for x-ray films features a new stainless steel Instant Grip film holder. Precision ball bearings acting on an inclined plane hold the films in place automatically. The Instant Grip extends across the entire top of the illuminator, thus permitting easy insertion or removal of any sized film, along its entire length. The illuminator body is fabricated of heavy gauge steel and the two 15 watt flourescent tubes provide even illumination over the entire Plexiglas viewing panel. **Halsey X-Ray Products, Inc., 1425 37th St., Brooklyn 18, N.Y.**

For more details circle #311 on mailing card.

(Continued on page 220)

Fiberglas Panels Are Fire-Resistant

Alsynite #200-FR is a new translucent fiberglas panel which is self-extinguishing and fire-resistant. It is designed for such structural and decorative applications as skylights, sidelights, partitions, shower doors, awnings and similar uses. Alsynite is made by combining resins and fiberglas under heat and pressure. The new product has good weathering qualities and adequate color stability. Panels are available in maize, light green and opal. **Alsynite Company of America, 4654 DeSoto St., San Diego 9, Calif.**

For more details circle #312 on mailing card.

Disposable Sheath for Colostomy

For comfort and convenience, the new Binkley Plastic Toilet Sheath is disposable. It is an economical product which provides many advantages for the patient requiring this accessory. It eliminates cleaning of the sheath, eliminates odors, cuts time of irrigation and is disposable into the toilet bowl. The new sheath is easy to use and simplifies procedures. **United Surgical Supplies Co., 650 Halstead Ave., Mamaroneck, N.Y.**

For more details circle #313 on mailing card.

Towel Waste Reduced With Push-Button Control

Consumption of paper towels is reduced appreciably by the new "Push-Button Control" Towel-Dispensing Cabinet recently introduced. The dispenser is designed for use with Mosinee Turn-Towls which are provided in roll form. The cabinet has been pre-tested in institutional and industrial washrooms and has proved highly satisfactory. It is easy to operate but provides the desired control that discourages waste of towels. A button in front of the cabinet is pushed, then a small crank at side of cabinet is turned and a single towel is available. One of the absorbent, strong and soft textured towels is sufficient for most needs.

The new dispenser has a rugged mechanism, but in case of damage it can be

completely removed and replaced with a new dispensing mechanism, causing practically no interruption in towel service. **Bay West Paper Co., Green Bay, Wis.**

For more details circle #314 on mailing card.

Wesley Memorial Hospital

CHICAGO

finds Hexachlorophene Germa-Medica antiseptic liquid soap in scrub-up assures thorough asepsis!

Surgeons and nurses at Wesley Hospital in Chicago scrub-up with Hexachlorophene Germa-Medica. It's the soap preferred for "prepping" patients, too. It is used because it saves time in the busy operating schedule and assures as nearly perfect cleansing of the skin as is possible. Though price is a secondary consideration, Hexachlorophene Germa-Medica makes important savings. It may be diluted before use with 3 or 4 parts of water, according to preference. A complete scrub-up actually costs less than 1/5 of a cent. Compare quality *and price* and you'll choose Hexachlorophene Germa-Medica, too!

Hexachlorophene Germa-® Medica

Contains 2½% Hexachlorophene on the anhydrous soap basis. 1% total weight.

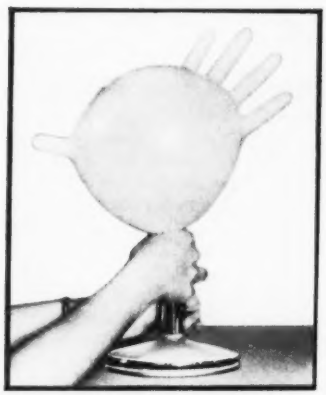
ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

A PRODUCT OF HUNTINGTON LABORATORIES, INC., HUNTINGTON, INDIANA • TORONTO, CANADA

NOW— *new ease, new efficiency in testing and powdering surgical gloves!*

The brand new McKesson Glove-Testing and Powdering Equipment

Nurse or assistant sits up to table, same as a desk.

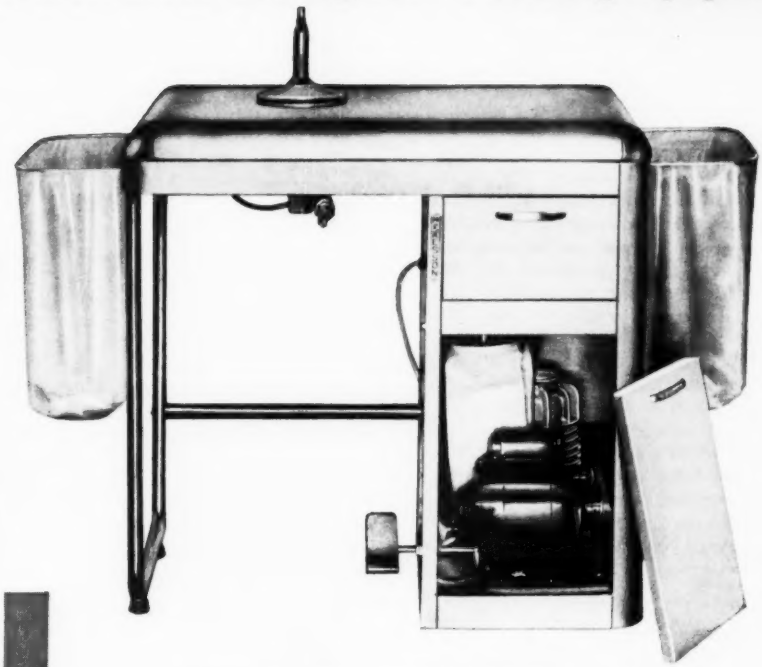


Press toe down on top of treadle and ¼-horsepower compressor inflates glove to desired size in matter of moments, spraying powder clear to fingertips at same time.

Each finger may be inflated for special precaution or to doublecheck on possible flaw.

Gloves to be tested are placed in plastic detachable bag at left side of Unit. Tested gloves are dropped in bag at right. Adjustable control assures precise amount of powder needed. Gloves are then ready for sterilization.

Ease and efficiency at its best! Faster, more economical, more uniform! A sure way to eliminate the tiniest flaw!



Operation and Details of McKesson Glove-Tester

Powder or starch-base material is loaded into powder container from top of equipment, simply by removing container cover . . . Three positions on treadle control—down to inflate, half-way up to hold inflation, heel down to deflate . . . On deflation, powder exhausts back into powder container, and any excess powder in exhaust line is trapped by vacuum-cleaner-type bag installed in compressor compartment . . . Powder and supplies are stored in deep utility drawer at top . . . Top of plastic bags slips into sturdy, chrome-plated steel band, the ends of which fit into firm sockets. Bags are easy to install and remove . . . Top and fittings are of stainless steel. All fittings chrome-plated. Rest of equipment of Silverlite hammer-finish.

McKesson

GLOVE-TESTING AND POWDERING EQUIPMENT

Get McKesson's Glove-Tester Brochure. It's yours for a postcard, letter or phone call.

McKESSON APPLIANCE COMPANY • TOLEDO 10, OHIO • Phone GArfield 4941

What's New . . .

Sculpture Form Used in New Seating

A group of modern, attractive seating pieces has been designed by Joe Adkinson for Thonet. Conveying the feeling of "sculpture and suspension," the pieces have wood frames gracefully shaped. The seating units are set into the frame in such a way as to seem to be floating on air although firmly supported by the frame. Pieces in the same design are available with one seat, two seats and three seats. The two and three seaters feature self-contained separate seats for each person rather than a continuous seating surface. Seats and backs are filled with 4 inch molded foam rubber and soft goods or plastics are available as covers. The wood frame is available in natural, maple, walnut, mahogany or black enamel finishes. **Thonet Industries Inc., 1 Park Ave., New York 16.**

For more details circle #315 on mailing card.

Identification System for Adult Patients

The Presco Identification System, long used to ensure infant identification in hospitals, has now been adapted for use on adult patients. Such identification has been indicated as helpful in assuring proper treatment and procedures for adults in multiple bedrooms, in surgery cases, for patients with speech handicaps or who are unable to speak English, and for other cases.

The Presco adult identification procedure consists of an identification bracelet of soft, non-irritating plastic which is placed on the patient's wrist in a matter of seconds. The patient's name is typed on a nameplate card which fits into the bracelet and additional data can be included. The unit is low in cost, easy to use and helps to ensure proper treatment. **Presco Co., Inc., 218 Fifth Ave. W., Hendersonville, N.C.**

For more details circle #316 on mailing card.

Iodine Disinfectant for Shower and Bath Rooms

Iodine is combined with a compatible synthetic detergent to form Showersan, a new disinfectant designed to prevent the spread of Athlete's Foot in shower rooms and bath rooms, on walls, floors and fixtures. The special formula renders the iodine non-irritating and non-staining, while keeping its effectiveness. Its detergent action renders Showersan an effective cleanser that penetrates cracks and crevices to clean and sanitize in one operation. **West Disinfecting Co., 42-16 West St., Long Island City 1, N.Y.**

For more details circle #317 on mailing card.

Maintenance Costs Cut With Wall Machine

A redesigned and improved model of the Wall Deterger has been announced. The machine, designed to wash walls speedily, is constructed of stainless steel and other non-corrosive metals and weighs only 42 pounds. It is highly mobile. A special low-cost attachment permits two men to operate from one machine, further speeding wall washing operations.

With the new detergent supplied with the machine only washing and buffing are required to clean the wall. The detergent is designed to clean effectively without streaks, with no harm to paint, and without odor. Use of the machine and detergent leaves walls in good condition for repainting. The Deterger operates by pressure which is built up in the pressure tank by an easy-to-operate hand

pump. The liquid is controlled by a finger trigger on the glides. **Von Schrader Manufacturing Co., 16th St. & Junction Ave., Racine, Wis.**

For more details circle #318 on mailing card.

Fabric Wall Coverings in New Designs

Several new designs and colors especially appropriate for hospital decoration are included in the 1954 line of Wall-Tex fabric wall coverings. The line includes prints and textured designs in a variety of colors as well as 21 solid colors. Patterns and designs suitable for patients' rooms and for lobby and waiting rooms are included in the line.

Wall-Tex has a sturdy fabric base which protects plaster and hides cracks. The material is pre-trimmed, ready to paste and hang, and comes in rolls 24 inches wide. **Columbus Coated Fabrics Corporation, 1230 N. Grant Ave., Columbus 16, Ohio.**

For more details circle #319 on mailing card.

(Continued on page 224)

Plastic Dispenser for Plastic Tape

Washable, waterproof Curad Plastic Adhesive Tape is now available in a new plastic dispenser. The new Curad Tape washes clean and stays on, even in soapy water. The special Curad Tape film backing is made to give proper elasticity and flexibility and to conform to body contours. The new-type Curad Tape plastic dispenser dispenses 207 inches of ½ inch Curad Tape. Tape can be cut to desired length by the lid, which saves time and energy and requires no scissors or other extra tool. **Bauer & Black, 309 W. Jackson Blvd., Chicago 6.**

For more details circle #320 on mailing card.

Insulating and Acoustical Plasters Are Incombustible

Two new building materials have been developed which are incombustible and which will adhere to metal, wood, brick or concrete without reenforcing attachments. Softone Acoustical Plaster has a cork base and is particularly suitable for use in institutions where fire safety, noise reduction and attractive appearance are important. It is a sanitary, washable material that will not harbor vermin or permit fungus growth.

Atoz Thermal Insulation is a fiber base plaster designed to withstand abrasion and vibrations which can be plastered directly to the corrugated cover without the use of mechanical anchorage or other surface treatment for the interiors of steel buildings. Both products are shipped in dry form and are troweled on the desired surfaces after being mixed. **Kragor Corporation, 884 N. Graham St., Allentown, Pa.**

For more details circle #321 on mailing card.

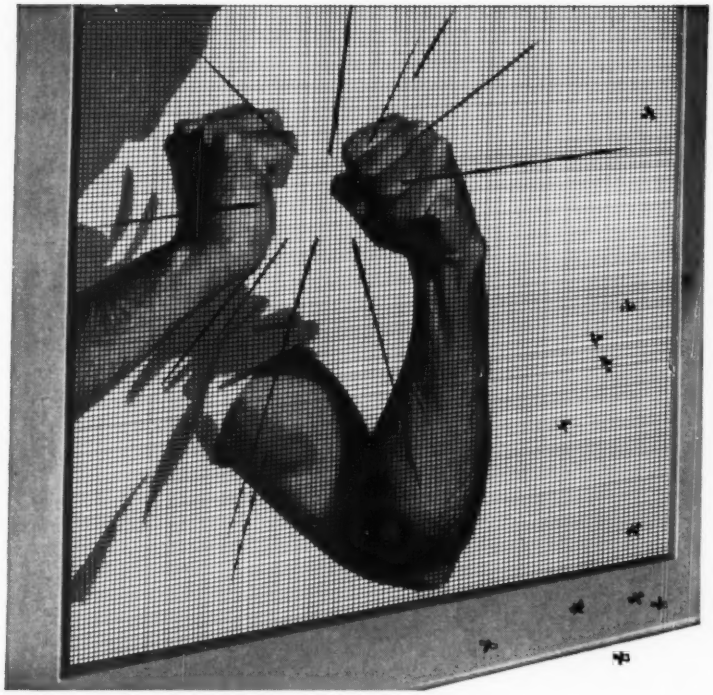
Individual Glass Bedside Water Set

An attractive, practical, individual water set is now available in glass. The water bottle, with cover which doubles as the drinking glass, has no handle, yet it is easy to hold for pouring because of the design. The glass tumbler, when inverted, fits into the water bottle as a snug cover to keep the contents clean.

Known as the Bedsider, the set is carefully made of fire polished pot glass, is

strong and rugged to resist cracking and breaking, and is easily cleaned. It is 8 inches high and has a capacity of 27 ounces. **Canton Glass Co., Marion, Ind.**

For more details circle #322 on mailing card.



Chamberlin Security Screens provide maximum detention; eliminate *all* insect screen costs

You save all insect screen costs. Close-woven, high-tensile-strength wire of Chamberlin Security Screens takes place of insect screening, withstands years of violent abuse. Admits ample light and air.

You cut sash repairs and painting costs. Chamberlin Security Screens, mounted at recommended distance from windows, stoutly resist attack, help prevent costly damage to window frames, sash, paint.

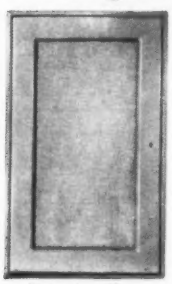
You reduce glass breakage. Inside mounting of Chamberlin Security Screens reduces window-glass breakage, cost of glass replacement, patient injury.

You reduce the threat of disaster. No grilles, no bars to trap your patients in a fire. No stubborn locks hinder their rescue. Exclusive Chamberlin emergency release permits instant patient removal from outside.

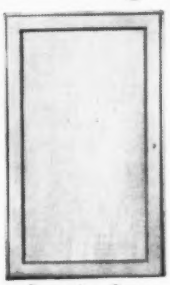
You cut grounds maintenance costs. Patients can't throw litter out of window, can't store it on window sill, can't receive forbidden objects by pass-in.

Over the years, these savings will more than offset your original costs. Yet they're only *part* of the savings and services other hospital administrators count on every day (see right). Let our Hospital Advisory Service give you full details. Write today.

The right screen at the right cost to fit your patients' needs



Detention Type



Protection Type

Safety Type

Chamberlin Detention Screens provide *maximum* detention and protection. Their heavy steel frames wired with high-tensile-strength wire cloth suspended by concealed springs to absorb shock, reduce injury to both patient and screen. Chamberlin Protection and Safety Screens provide suitable and economical protection for nonviolent patients.

QUICK NOTES

on savings and services provided by Chamberlin Security Screens

In the last fourteen years, over 80,000 Chamberlin Security Screens have provided these and additional savings and services to hundreds of hospitals in almost every state of the U.S. and in numerous foreign countries.

Chamberlin Security Screens reduce maintenance time, effect material savings; replace heavy bars and guards. Replace insect screens. Stop glass breakage and damage to window frames and sash. Reduce painting requirements. Reduce grounds maintenance work by keeping litter in rooms.

They reduce cost of medical care for physical injury: prevent self-damage and attacks on attendants with broken glass. Prevent cold-inducing drafts. Prevent suicide attempts by hanging from window muntins, grilles, bars. Prevent receipt of dangerous pass-in objects.

They provide more cheerful atmosphere. Supplant depressing jail-like bars and grilles. Make room interior more homelike; keep building's exterior uncluttered. Admit ample light and summer air.

Chamberlin Security Screens *supplement* supervision. Special Chamberlin locking device resists tampering and plugging attempts. Close-woven, high-tensile-strength wire mesh foils usual picking and prying. Smooth frame edges and rounded corners preclude accidental or intentional self-damage. Screens can be provided with emergency release permitting instant patient removal by operation of lock from outside.

Modern institutions turn to

CHAMBERLIN

CHAMBERLIN COMPANY OF AMERICA

For modern detention methods

CHAMBERLIN COMPANY OF AMERICA

Special Products Division

1254 LA BROSSE ST. • DETROIT 32, MICH.

CHAMBERLIN INSTITUTIONAL SERVICES also include Rock Wool Insulation, Metal Weather Strips, Calking, All-Metal Combination Windows, Insect Screens, Building Cleaning, Tuck Pointing, and Waterproofing.

In left graduate: BAROTRAST in water, after standing 24 hrs.
Right: Barium Sulfate U. S. P. in water, after standing 24 hrs.

IN THE COMPLETE LINE OF WESTINGHOUSE X-RAY ACCESSORIES—

Contrast Media for Increased Visualization

Westinghouse X-ray equipment is backed up with a fine, full line of accessories. Item: contrast media of superior physical characteristics to aid visualization. Here are three examples:

Barotrast — a newly developed, fine-particle barium sulfate. Makes a uniform, *non-separating* suspension that is tenacious, elastic, of even opacity and controlled viscosity. In air contrast work: positive shadows, unusual delineation. In 25-lb drums.

Mulsopaque — aqueous emulsion of ethyl iodophenylundecylate. Virtues: low viscosity, low surface tension, miscibility with tissue fluids, excellent adherence to mucous. For gall bladder; ducts of biliary tree, breasts and salivary glands; sinus tracts; empyema cavity; fistulas tract. In boxes of four 10-cc ampoules.

Pantopaque — a homogeneous opaque for X-ray visualization of lesions of the spine and cord, especially at nerve roots. Can be almost entirely expirated. In boxes of three 3-cc or six 6-cc ampoules.

In common with all chemicals supplied by Westinghouse for diagnostic purposes, Barotrast, Mulsopaque and Pantopaque are manufactured to exacting standards. Quality, of course, is the sina qua non of the entire Westinghouse line of X-ray accessories. That's why it is especially convenient for you to rely on Westinghouse for all your accessory needs. You'll find your Westinghouse representative a willing aid in keeping these needs satisfactorily filled. Call him. Or write Dept. E-94 at the address below.

X-RAY DIVISION • WESTINGHOUSE ELECTRIC CORPORATION • BALTIMORE 3, MARYLAND

FLUOREX
PORTABLE UNITS
X-ACTRON
WESTLINE CABINETS
MONOFLEX
PFX
FLUORADEX
DUOCONDEX
SERVICE
ACCESSORIES

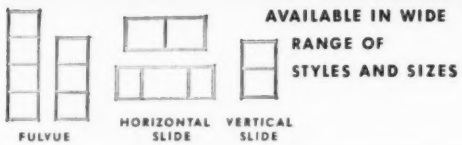
YOU CAN BE SURE...IF IT'S

Westinghouse

J-08294

What is Your Window Problem?

(CHANCES ARE, RUSCO OFFERS YOUR BEST SOLUTION)



AVAILABLE IN WIDE RANGE OF STYLES AND SIZES

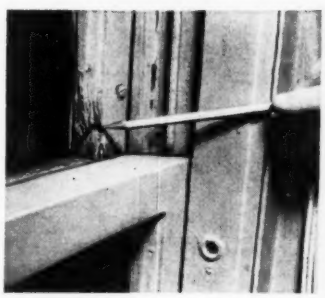
Want "more window" at less cost?

Rusco Prime Windows offer truly exceptional characteristics of functional convenience, weather tightness and economy. Because they are fully prefabricated, ready-to-install units—glazed, finish-painted with baked-on enamel, fully weather-stripped—field work and installation time are greatly reduced. Installed cost is often lower than that of the *cheapest* windows you could buy! Sliding glass panels are removable from inside for easy cleaning and maintenance. Available with Rusco's special insulating sash and Fiberglas screen, if desired.

Present windows in need of replacement or modernization?

Rusco has developed special methods and complete window units that can replace or modernize inefficient, worn-out windows far faster and less expensively than is possible by conventional methods. Photos at right show a typical example in Hotel Hollenden, Cleveland, Ohio. Suite in which these photos were made was back in service the *same day*, with windows fully replaced by Rusco Windows complete with insulating sash!

BEFORE



AFTER

Need windows that "lick" the air conditioner problem?

The Rusco Air Condition Window is the world's first window unit designed to accommodate any type of window air conditioner. Completely replaces conventional window. All glass panels, including flankers, are removable from inside for washing, eliminating window cleaning problems. An extra lower glass panel replaces air conditioner unit and flankers when unit is removed for storage or servicing.

Sealing problems are eliminated by the Rusco Air Condition Window. There is no air or soot leakage because it is a precision-made, weather-tight unit. Frames are tubular galvanized steel, finish-painted with baked-on enamel. Available with insulating sash for double glass insulation which gives maximum air conditioning efficiency.

RUSCO *Hot-Dipped Galvanized Steel* **PRIME WINDOWS**

For illustrated literature and name of your nearest Rusco Dealer, write
THE F. C. RUSSELL COMPANY
Dept. 6-MH54, CLEVELAND 1, OHIO
In Canada: Toronto 13, Ontario

What's New . . .

Asphalt Tile in Flagstone Design

A new design in asphalt tile is offered in Armstrong Flagstone. Instead of the simple block shape, Flagstone presents a custom effect in ready-made resilient tile flooring. It is based on an 18 inch grid principle into which vari-shaped pieces of asphalt tile are fitted. Three color schemes are available, each combining plain, straight grain and swirl marbleized pieces. **Armstrong Cork Company, Lancaster, Pa.**

For more details circle #323 on mailing card.

Solid Food Shortening Offered for Institutional Use

Four types of quality vegetable shortening have been made available by Kraft especially for institutional use. All four products are packaged in different colors for easy identification and are available in 50 and 110 pound tins. Each product was developed to meet a specific institutional food preparation need, and include Blue, Brown and Green Label solid shortening.

Blue Label is an extra refined, pure vegetable product for all uses. Red Label is a special deep fat frying shortening. Brown Label has been specially formulated for baking. Green Label is a pure vegetable "standard shortening." With the exception of Green Label, all Kraft shortenings are hydrogenated. **Kraft Foods Co., 500 Peshigo Court, Chicago 11.**

For more details circle #324 on mailing card.

Tube Support Crane for Gas Machines

Regarded as necessary adjunct to a gas-piping system, the new McKesson Tube Support Crane carries gases from wall valves to the anesthesia machine at the operating table. It was designed and developed in cooperation with Dr. Lucien E. Morris, State University of Iowa. When not in use the crane folds and lies flat against the wall. In use it supports the tubes six feet from the wall, overhead and out of the way.

A McKesson Wall Valve for each gas is located below the crane to assure positive shut-off. Tube ends are equipped with Schrader Safety-Keyed Quick Couplers so that the machine may be quickly disconnected from the lines and stored. **McKesson Appliance Co., 2228 Ashland Ave., Toledo 10, Ohio.**

For more details circle #325 on mailing card.

Disposable Cups and Holder for X-Ray Darkroom

An unbreakable plastic cup holder that glows in the dark, with disposable paper cups and an aluminum dispenser, make up the Keleket Handy Triple Combination. It is designed for use in the darkroom for quick access to cups and to avoid spillage. Paper cups are printed with the words "Barium Cup", each of which has 14 ounce capacity. A dosage scale graduated in ounces and cc's is printed on the cup. The brushed aluminum dispenser which holds 100 cups can be wall mounted or equipped with a polished chrome stand for desk, shelf or cabinet mounting. **The Keleket X-Ray Corporation, 212 W. Fourth St., Covington, Ky.**

For more details circle #326 on mailing card.

Individual Room Heat Control With SelecTemp System

The Iron Fireman Selec-Temp heating system has been used in various types of buildings for the past three years. This

research and testing have proved so satisfactory that the system is now being put on the market nationally.

The system features a thermostat in every room and continuous circulation of filtered warm air. Each heater is a fully automatic unit, consisting of a copper heat exchanger, steam turbine driven fan for circulating room air, air filter, and a self-contained non-electric thermostat. It is designed to compensate for lower outdoor temperatures and for indoor heat, including sunlight and body radiation. Temperatures suitable for each room or area are automatically held at the designated degree for greatest comfort.

The recessed wall units require no floor space and can be finished to harmonize with any interior color scheme. The thermostats require no wiring and circulating air is cleaned by a removable spun glass filter in each unit. The boiler can be placed in any convenient location in the building, with proper distribution of heat to every room.

The individual SelecTemp room heating units operate independently and thermostats can be set at any temperature from 40 to 90 degrees. The system can be economically installed in both new and existing buildings. Fuel is saved through reduced temperatures in unused areas and the elimination of overheating. **Iron Fireman Manufacturing Co., 3170 W. 106th St., Cleveland 11, Ohio.**

For more details circle #327 on mailing card.

(Continued on page 228)

Stainless Steel Washer Has Quiet Drive

The 30 inch Junior Stainless Steel Washer, intended for use in small institutions with moderate daily work loads, or as an auxiliary to handle small lots or special loads, has a newly designed, quieter drive. It consists of a combination of V-belt and spur gears and gives the heavy-duty washer extended noise-free, dependable service.

The drive on the 24 inch model has also been improved and operates by a combination of spur gears and roller chains. Both models have standard safety features including electrical interlocks to prevent accidental starting when the washer door is open and fully enclosed guards on all exposed parts of the drive mechanism. **U. S. Hoffman Machinery Corp., 105 Fourth Ave., New York 3.**

For more details circle #328 on mailing card.

Window Air Filter Cools and Heats

Fresh, filtered air, free from dust and pollen, is supplied with the new Therm-Aire electric window air filter. A highly sensitive thermo-switch operates an automatic heater and adjusts to changes in outdoor temperature as well as changes in room temperature. This ensures a steady flow of fresh outdoor air preheated to the desired room temperature, with all dust and pollens removed. In warm weather the Therm-Aire re-circulates and re-filters the air, acting as a fan.

The Therm-Aire can be readily installed in any standard window. Filters are easily replaced when dirty and last approximately a month. Double filters account for the high efficiency in pollen removal. Medication can be sprayed on the front filter if desired. The unit is available in four models with optional

accessories for timing, humidification and electro-static filter. It requires no special wiring or plumbing. **Air-Net Filter Co., 1550 E. 53rd St., Chicago 15.**

For more details circle #329 on mailing card.

Exceptional Washability

Just *One of 9 Desirable Characteristics* of this Better Alkyd Flat Enamel for Walls and Trim

This machine is used by the Pratt & Lambert laboratories to test the washability of paints. The weighted sponge moves across the painted surface 2,500 times an hour. A paint is judged by the number of strokes required to remove streaks of such substances as ink, crayon, lipstick and mercurochrome — and by its ability to resist wear and disintegration resulting from this scrubbing.

HERE ARE THE 9 DESIRABLE CHARACTERISTICS

1 WASHABILITY — It's actually scrubbable

2 EASY APPLICATION — With brush or roller

3 HIDING — One coat usually covers previously-painted surfaces

4 SELF-PRIMING — No special primer required

5 NO OBJECTIONABLE ODOR — During or after painting

6 FAST DRYING — Paint in the morning; use room same day

7 FOR ANY WALLS — Plaster, wallboard, wood, metal, concrete and cinder blocks

8 ECONOMICAL — Extra durable; fewer repaintings

9 BEAUTIFUL COLORS — 24 de luxe Calibrated Colors and white

Washability is one of the most important factors in economical painting maintenance. So Pratt & Lambert technicians tested 635 formulas to make the *New* Lyt-all Flowing Flat exceptionally washable — and to give it all the other qualities you want in a paint for walls and trim.

Though velvety-smooth in appearance, the surface of *New* Lyt-all Flowing Flat is actually so hard that dirt can't penetrate. Even hard-to-remove substances like mercurochrome, ink, lipstick and crayon wash off easily.

Here, then, is your answer to a wall paint that cuts costs by lasting longer and giving you more washings between repaintings. Judge for yourself — try Pratt & Lambert *New* Lyt-all Flowing Flat on your next job.

PRATT & LAMBERT-INC.

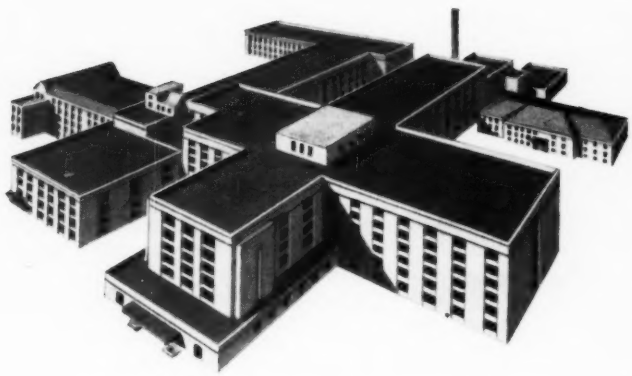
A Dependable Name in Paint Since 1849

NEW YORK · BUFFALO · CHICAGO · FORT ERIE, ONT.

$2,500,000 GOAL

OVERSUBSCRIBED IN

UNITED HOSPITAL CAMPAIGN



Aultman Hospital, as it will appear when expansion is completed. Herman J. Albrecht, architect. R. W. Bachmeyer, director.

In 1950, this firm directed a successful campaign which raised about $2,000,000 for Aultman Hospital at Canton, Ohio. Two years earlier, Mercy Hospital had raised about $1,500,000 to launch its building program.

This year, under our direction, a United Campaign for the largest goal ever sought in Canton raised $2,640,000 in pledges for Aultman and Timken-Mercy Hospitals.

Mr. Richard G. McCuskey, Chairman of the Joint Hospital Committee, wrote that "This victory would not have been possible without the very fine job that was done by your staff." Mr. D. A. Bessmer, Campaign Chairman, commented: "I have the highest praise for your staff."

Timken-Mercy Hospital according to architect's conception. Schmidt Garden & Erikson, architects. Sister M. Henrietta, administrator.

FIGURES PROVE THAT 1954 IS A GREAT YEAR FOR HOSPITAL CAMPAIGNS!

HOSPITAL	GOAL	PLEDGED
Ohio Valley General, Wheeling, W.Va.	$1,500,000	$1,889,000
Conemaugh Valley Memorial, Johnstown, Pa.	$1,300,000	$1,850,000
East Liverpool City, East Liverpool, Ohio	$ 750,000	$1,025,000
Southside, Bay Shore, N.Y.	$ 900,000	$ 933,000

Administrators and board members are cordially invited to consult us without obligation.

KETCHUM, INC.

Campaign Direction

CHAMBER OF COMMERCE BUILDING, PITTSBURGH 19, PA. AND 500 FIFTH AVENUE, NEW YORK 36, N.Y.
CARLTON G. KETCHUM, *President* • NORMAN MAC LEOD, *Executive Vice President*
MC CLEAN WORK, *Vice President* • H. L. GILES, *Eastern Manager*

Member American Association of Fund Raising Counsel

What's New . . .

Nipple Covers for Terminal Sterilization

Protection of nipples on bottles of formula, during sterilization and until used, is offered in Davol Sani-Caps and Termi-Caps. These conveniently used covers are placed lightly over the nipple before sterilization of formula bottles. While bottles are cooling the caps are pressed firmly over the nipples, forming a proper seal. They are quickly removed when formula is ready to be used.

The protective caps will withstand repeated sterilization, resulting in economy of use. Sani-Caps are designed for use on standard sized bottles and nipples, and Termi-Caps on wide-neck bottles. **Davol Rubber Co., Providence 2, R.I.**

For more details circle #330 on mailing card.

Highly Absorbent Cloths Are Disposable

Soft, fleece-like cloth of cotton and rayon is used in the new Chix (R) Absorbents. They are especially made for various hospital uses, are disposable, yet possess great tensile strength and body, both dry and wet. They are designed to save nurses' time, for greater patient comfort, and to reduce laundry expense. They are sterilizable and are made in a 13½ inch square to be used as a disposable wash cloth for adults, for perineal care, for treatment of bed sores since it can be applied next to wounds without sticking, and as wipes for colostomy patients. They are also available in a smaller size which can be used as infants' wash cloths, as diaper liners, prep cloths for surgical patients, instrument tray liners, and other uses. They are made of Masslinn(R) non-woven fabric. **Johnson & Johnson, New Brunswick, N.J.**

For more details circle #331 on mailing card.

Quick Drying Latex Paint for Interiors

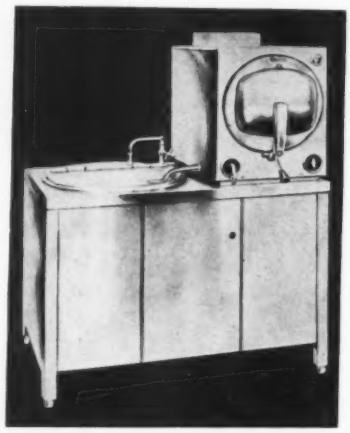
A new low priced latex paint for interior surfaces has no chemical odor. Painting can go on in rooms and corridors adjoining those which are occupied, without discomfort from odors. It is fire retardant to applied surfaces, non-inflammable and non-toxic. The paint dries quickly so that when needed a second coat can be applied in three hours. No priming is required since the primer is built into the paint which is low in cost and has high hiding power. It is available in non-yellowing white with nine tint colors for mixing a wide variety of shades. The paint covers in a single coat, dries to a hard, smooth finish which can be washed, and gives a durable surface even over new plaster. **F. O. Pierce Co., 2-33 50th Ave., Long Island City 1, N.Y.**

For more details circle #332 on mailing card.

Pressure Cooker and Kettle in One Compact Unit

A new Model ST-KG Combination Steam-It and 20-Gallon Kettle has been developed to provide the advantages of steam pressure cooking and a steam-jacketed kettle in one unit. Steam is furnished by a large 2 h.p. gas-fired boiler, complete with controls, located in the cabinet under the Steam-It.

The Steam-It unit operates at 15 pounds steam pressure. Being directly connected to the boiler, the steam pressure builds up almost immediately. The steam-jacketed kettle is also directly connected to the boiler at the same pressure. Fuel is automatically controlled for economical operation of the combination unit. The unit offers fully-controlled, safe and efficient pressure cooking at low cost of labor, fuel and time. **Market Forge Co., Everett 49, Mass.**



For more details circle #333 on mailing card.

Comfortable Seating Offered in All-Aluminum Furniture

A series of chairs and settees is now available in anodized all-aluminum furniture. Included in the new group are an easy chair, a two-seater settee and a three-seater davenport. The furniture is made of 1½ inch square aluminum tubing, with seat pan of sheet aluminum, hard rubber arm pads and plastic glides. The unusually heavy seat and back cushions have coil innerspring construction, all new cotton felt upholstery filling, and are reversible. They are also available with foam rubber filling. **U. S. Chaircraft Mfg. Corp. 225 Belleville Ave., Bloomfield, N.J.**

For more details circle #334 on mailing card.

(Continued on page 232)

Water Still Has Visual Indicator

Pyrogen-free water for use in making up injectables can be produced with the new Pyrogen-Free Water Still recently developed for use in hospitals, laboratories and clinics. The new still features a Conductivity Recorder manufactured by The Bristol Company, which gives a visual indication of the purity of the water during distillation. The recorder measures and gives a permanent written record of the specific resistance of the distilled water, thus giving a continuous indication of the purity. **The American Sterilizer Company, Erie, Pa.**

For more details circle #335 on mailing card.

Adjustable Rack for Instrument Storage

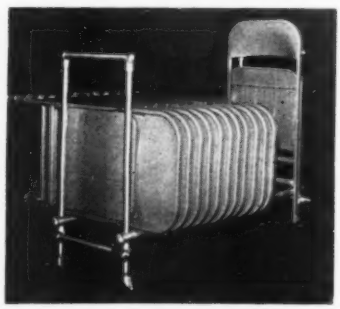
The Adjusta-Rak is a rigid steel bar mount, on which sturdy, non-slip hangers are easily hooked, lifted off and spaced as needed. The rack can be easily mounted in any instrument cabinet, storage or wall cabinet, or on the wall for handy, time-saving sorting and storage of surgical instruments. It requires a minimum of space, is completely flexible as to spacing and arrangement, and is available in any length to fit available space. **V. Mueller & Company, 320 S. Honore St., Chicago 12.**

For more details circle #336 on mailing card.

Folding Chair Truck Is Adjustable

The Pacific-Shaw Folding Chair and Table Truck is a patented carrier which is adjustable to any size of chair or table. The design is such that several makes or sizes of chairs may be safely and easily carried at the same time. Folded chairs can be stacked on the truck either upright or lying on the sides.

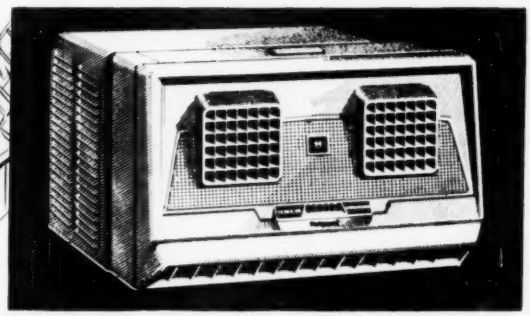
Made of high strength aluminum alloy of airplane type light weight, the tubular frame of the truck does not mar finish of chairs or tables. The trucks can be adjusted as used, and the adjustments made in height and width as required. Trucks are furnished in standard lengths, chair trucks with a maximum width of 20 inches, table trucks a maximum of 30 inches. **The Pacific-Shaw Co., P. O. Box 870, Portland 7, Ore.**



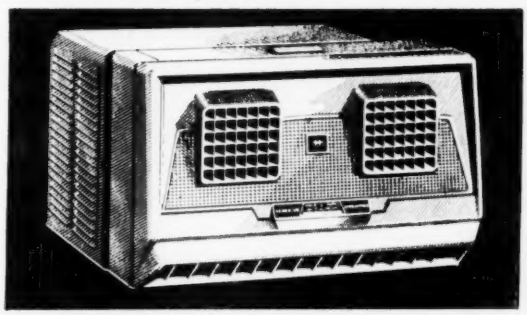
For more details circle #337 on mailing card.

Bring Them Cool Comfort with Hotpoint Room Air Conditioners

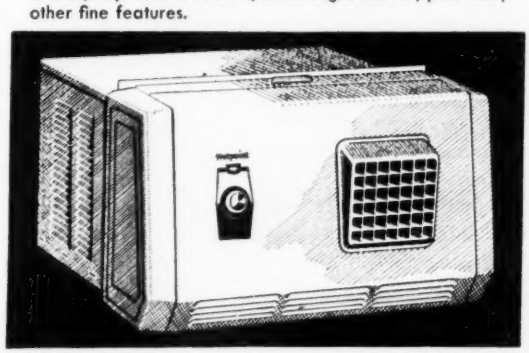
All convalescents can't go to a summer resort to recuperate, but they can enjoy the wonders of clean, cool, ocean-fresh air. In addition to the comforting effects of indirect, gently circulating cool air, patients will also breathe cleaner air because Hotpoint Room Air Conditioners filter out dust, dirt, and pollen. Room air can be completely changed in seconds, thus removing objectionable odors. Moreover, by removing up to 9 gallons of water from the air every day, Hotpoint relieves the humid discomfort of bed patients. And Hotpoint's super-silent operation could not disturb even the very lightest sleeper. Each of Hotpoint's 11 easily-installed, easily-operated models is backed up by a 5-Year Protection Plan. More and more modern hospitals are learning the advantages of good air conditioning. See your local Hotpoint dealer soon for full details on Hotpoint Year 'Round Air Conditioners. Find out how they can help you to serve your community better.



Hotpoint's finest 1 h.p. model with convenient push-button controls. Has Heater, 4-Way Air Circulation Grilles, Thermostat, and 2-Speed Blower.



Hotpoint's ¾ h.p. models. Have variable 4-Way Grilles, Replaceable Filters, Centrifugal Blower, plus many other fine features.



Hotpoint's dependable, economical Air Conditioners in compact ½ h.p. size. Have many features of large models.

Hotpoint ... Pacemaker of Progress!

RANGES • REFRIGERATORS • DISHWASHERS • DISPOSALLS® • FOOD FREEZERS • CABINETS
AUTOMATIC WASHERS • CLOTHES DRYERS • AIR CONDITIONERS • DEHUMIDIFIERS
HOTPOINT Co. *(A Division of General Electric Company)* ***5600 West Taylor Street, Chicago 44, Illinois***

SAVED

53½% IN REPLACEMENT COSTS IN 5 YEARS!

Hospitals, too,
can save with
Break-Resistant
Melmac® Dinnerware
the same as **Clifton's**
Los Angeles

Everyone in Los Angeles knows Clifton's, and Clifton's knows every fine service feature of dinnerware made of Melmac molding material. No wonder—after five years of cost-cutting experience with it!

Here's how Clifton's sees it—

"... there is no doubt that plastic dishes are saving us thousands of dollars each year through their durability"

and

"... our ware handlers are especially pleased with the light weight of Melmac; so is the patron, whose fully laden tray is much lighter than it would be if we used conventional dinnerware."

But—does Melmac withstand automatic dishwashing? Well, here's what it gets at Clifton's—has been getting for five years—

"... a 140° F pre-wash ... 160° wash ... first rinse 180° F and final rinse at 200° F, which also heats the dish to speed drying."

That says it—Melmac's a mighty money-saver that will pamper the patients, the help, and your budget! Ask your supplier to demonstrate Melmac's marvelous break-resistance, and you'll see what we mean. Or write us for the names of molders of Melmac dinnerware.

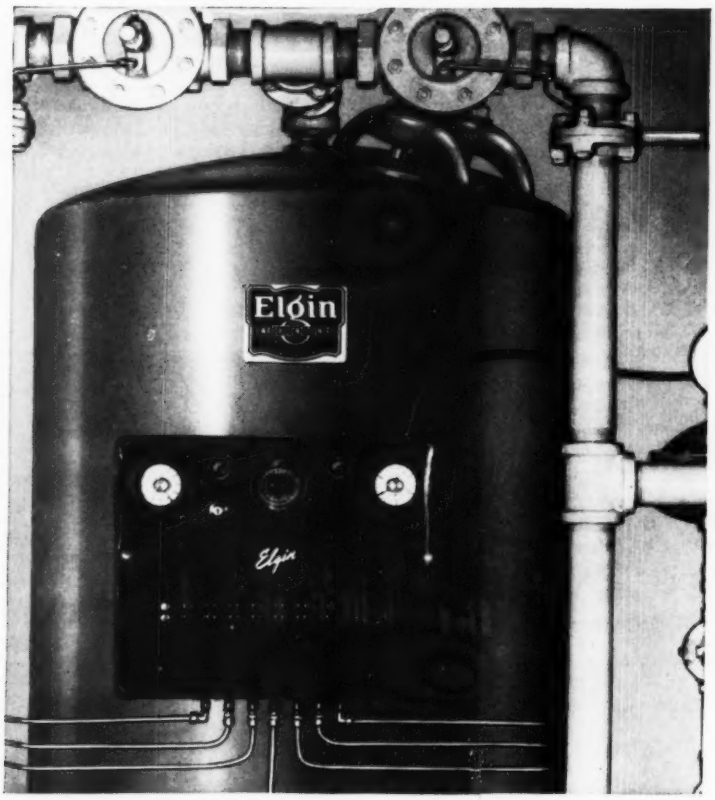
AMERICAN Cyanamid COMPANY

PLASTICS AND RESINS DIVISION
34F Rockefeller Plaza, New York 20, N. Y.

In Canada: North American Cyanamid Limited
Toronto & Montreal

Melmac is a registered trade-mark of American Cyanamid Company for Melmac Molding Compounds used in the manufacture of dinnerware and other modern products.

ELGIN ULTRAMATIC



America's Finest AUTOMATIC WATER SOFTENER

It's Hydraulically Operated by Magic Pilot

Costly Loss of Zeolite Prevented

The zeolite ion exchange material in this water softener is *"locked in"* by an ingenious "Double Check" manifold system to prevent costly loss, and to give more efficient regeneration. This manifold also permits far more exchange material to be placed in the softener to give up to 44% greater capacity so that a smaller unit will meet the need.

Your Softener Easily Converted to Automatic Operation

Save valuable manhours, eliminate human error, and increase the efficiency of your present water softener by converting to automatic operation. Write for details.

Here is today's most dependable automatic water softener—a product that sums up the best of all we have learned in nearly a half century of experience. It operates on the time proved hydraulic valve principle and is controlled by a new and unique automatic pilot to deliver a constant supply of zero soft water without attention.

The time interval and flow rate of each regenerating step of the Ultramatic is individually adjustable for maximum efficiency under any operating requirement or water characteristic. The reasons why this flexibility is highly essential to satisfactory performance, together with complete information about this water softener, are given in Bulletin 612. Write for your copy.

Elgin REFINITE SINCE 1908

ELGIN-REFINITE

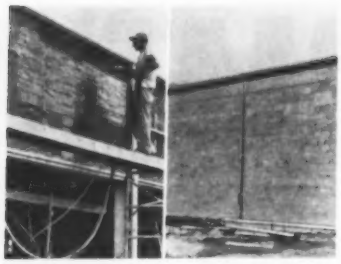
DIVISION OF ELGIN SOFTENER CORPORATION

144 NORTH GROVE AVENUE, ELGIN, ILLINOIS

In Canada: G. F. Sterne & Sons, Brantford

OTHER PRODUCTS WRITE FOR BULLETINS { Delonizers • Dealkalizers • Lime Soda Softeners • Deaerating Heaters • Filters • Treatment

What's New . . .



Concrete Spray Waterproofs and Strengthens

A new method of applying concrete for waterproofing as well as for wall construction is offered in Spraycrete. The specially designed Spraycrete equipment pre-mixes sand, water, cement and admixtures at high pressures, resulting in a mix that is easily applied by gun. The patented pre-mixing technic makes a product that gives complete waterproofing protection. Walls of any thickness can also be built of Spraycrete, or it can be applied over brick or tile construction to provide a smooth, waterproof surface, as shown in the illustrations.

Spraycrete high pressure pre-mixing eliminates shrinkage, achieves a perfect bond, and is achieved by the use of patented, heavy-duty, mixing equipment. **Western Waterproofing Co. of Michigan, 9960 Freeland, Detroit 27, Mich.**

For more details circle #338 on mailing card.

Platform Scale for Prone Patients

Specifically designed for hospital use, the new Toledo Hospital-Patient Scale provides for the weighing of patients in a supine or prone position. Known as Model 9281, the scale has a platform 33 inches from floor level, 6 feet 2 inches long by 2 feet wide. The patient to be weighed can be easily moved onto the platform for frequent checking of weight if desired. The scale is mounted on rubber tires for easy, quiet movement to the bedside or other area where needed. A push handle on the white enamel frame makes it easy to move, the wheels are of full swivel type, and each wheel has a foot-operated brake for firmly positioning the scale.

A 50 kilogram dial, graduated by 50 grams, is provided so that slight weight variations are easily detected. Double dial indication permits easy reading from either front or back, and the weight of any covering for the patient can be offset on the tare beam. **Toledo Scale Company, Toledo 1, Ohio.**

For more details circle #339 on mailing card.

Stainless Steel Wall Fountain Is Easy to Clean

The new SF-145 Ebco Wall Fountain is made of stainless steel with mirror finished top and satin finished skirt. It is an attractive, sanitary fountain which is easy to keep clean and inviting in appearance. It may be connected to any water supply or water cooler and is furnished with bubbler. A glass filler may be added using piped, capped outlet.

The stainless steel top has rounded corners to prevent splashing. The skirt improves appearance and sanitation, and condensation is prevented by rock wool insulation. A polished stainless steel strainer and chrome plated brass waste drain and brass stop valve are part of the fountain. It projects 14⅜ inches from the wall and is 15⅛ inches wide. **The Ebco Manufacturing Co., 401 W. Town St., Columbus 8, Ohio.**

For more details circle #340 on mailing card.

(Continued on page 236)

Hospitals Save Time—Money—Space with Filmsort®

Filmsort Jacket holds 60 case histories

More and more hospitals are taking advantage of *Remington Rand Filmsort* to *cut* their record-keeping costs —*slash* clerical time—and *conserve* on filing space in maintaining their huge lists of patient case histories. Filmsort is *unique* because it utilizes the streamlined compactness of microfilming records plus the ingenious space-saving device called the Filmsort Jacket—which completely eliminates filing microfilmed records on bulky reels. Instead, a single Jacket will hold as many as 60 case histories . . . 60,000 medical records to one filing cabinet. With this super-efficient set-up, you have indexes and actual records all on one card. The whole story is yours in *only one simple step!* For immediate reference to any case history in your files—you merely place the proper Jacket in a Filmsort Reader. The most

Reader magnifies record on 11"x11" screen

popular Reader is a portable, desk-top model weighing less than 20 pounds. Equipped with a fine lens and focal system, you get an exceptionally clear, sharp image on a 11" x 11" translucent screen. Microfilm records appear as clear as the originals, even in direct light. Crystal sharp enlargements can be made on wall or screen by merely removing bottom and tipping Reader on its side. For a more detailed story write for *free* folder F575.

Although Remington Rand maintains a complete line of microfilming equipment and Readers for sale or rent—you needn't invest one single penny in any of these items. A competent staff of Business Services experts stand ready to microfilm your records, either in your hospital or at our Service Center, using only the latest in Remington Rand Equipment. Get the complete details from folder BSD5A. It's yours *free*.

More Quiet—Greater Efficiency for Clerical Staff

So quiet—like typing on a pillow!

Quiet is not only necessary in the sickroom, but your hospital office demands it too, if your clerical staff is to operate efficiently. Surveys prove conclusively that neater and more professional looking letters and records are obtained more easily when produced in quiet surroundings.

Alert hospitals, similar to business firms, are using this important fact to their advantage by installing Remington Noiseless Typewriters in all their offices. By simply cutting down on office noise, a greater volume of sharp, clear records and paperwork is produced in far less time—with fewer errors.

However, for a first-hand report on how you can obtain these proven time and work-saving advantages, Remington Rand offers, *free*, a color brochure. It shows how easily you can *eliminate* office typing noise that reduces operator efficiency and *drains* energy. The increased quality and quantity of work produced with the Remington Noiseless in quiet office surroundings will simply *amaze* you. Write now for RN8435.1.

11 Hospital Records in Just One Writing

With Remington Rand Manifold Admissions Forms, you get 11 hospital records, all on one patient, in *just one writing*. Now, with this remarkable cost-cutting, time-saving device, each interested department in your hospital is given a complete legible record in only minutes after the patient has been admitted.

Typical of the hundreds of installations everywhere that are turning to the Remington Rand Manifold Admission Forms for super-speed and accuracy in admitting patients, is the Emergency Hospital of Buffalo, N. Y. From *just one writing* they obtain the following forms: 1. Admission Records; 2. Switchboard Index; 3. Information Desk Index; 4. Patient History Sheet; 5. Ledger Sheet; 6. Case History File; 7. Interne's Record; 8. Notice to Superintendent; 9. Floor Record; 10. Operating Room Notice; 11. Office Admitting Room Record.

With this unique system, you too, can get 11 records from *one writing*. And with forms 4 to 11 made as carbon copies, you're afforded an unbeatable combination of speed and accuracy. Transcription errors are impossible. Responsibility for accurate, complete records is centralized. Copies are ready when needed. Only necessary information reaches each department. Your hospital's entire activity is directed and controlled from the original information. But don't delay any longer, find out *now* without cost or obligation how simply your hospital can *cut* clerical work and costs right down to the bone. Send for *free* literature MC742 and SN615.

Remington Rand

Room 1560, 315 Fourth Ave., New York 10
Please circle literature desired:

F575 BSD5A RN8435.1
MC742 SN615

Name_____
Title_____
Hospital_____
Address_____
City_____
H-5

— Profit-Building **IDEAS** For Business —

Best Bet Bassinets are WILSON'S

Aluminum
Lynn Model #3201-A

Stainless Steel
Wiley Model #1248-S

WILSON offers a quality line of stainless steel and aluminum alloy bassinets in a variety of styles and models to suit your own specific technique. The WILSON line begins with a simple basket-stand model and includes models with a wide range of related accessories. They're all practical in design, and are of sturdy, all-welded construction with all joints ground smooth and clean for easier cleaning and sterilization.

Aluminum
with Isolation Cabinet
Margaret Model #3202-A

Stainless Steel
with Isolation Cabinet
Warren Model #1247-S

CUSTOM MADE BASSINETS

Perhaps you have wanted a *specially designed* bassinet that would better serve *your particular needs*. Bassinets to *your specifications* will be built by Wilson. We will be happy to serve you.

- Anesthetist Stools
- Anesthetist Tables
- Arm Immersion Stands
- Bassinets
- Basin & Arm Immersion Stands
- Bedside Screens
- Biopsy Tables
- Clysis Tables
- Commode Chairs
- Dressing Carriages
- Drum Stands
- Foot Stools
- Glove Racks
- Instrument Cabinets
- Instrument Stands
- Instrument Tables
- Irrigator Stands with Percolator
- Irrigator Stands
- Linen Hampers
- Mayo Stands
- Nurses Work Tables
- Observation Stands
- Operating Stools
- Operating Tables
- Solution Stands
- Sponge Racks
- Sponge Receptacles
- Tray Carts
- Treatment Cabinets
- Treatment Chairs
- Utility Tables
- Wall Stands
- Wheel Stretchers
- Work Tables
- Special designs built to your specifications

Aluminum
Isolation Bassinet
Mary Model #3203-A

Stainless Steel
Isolation Basinnet
Herman Model #1250-S

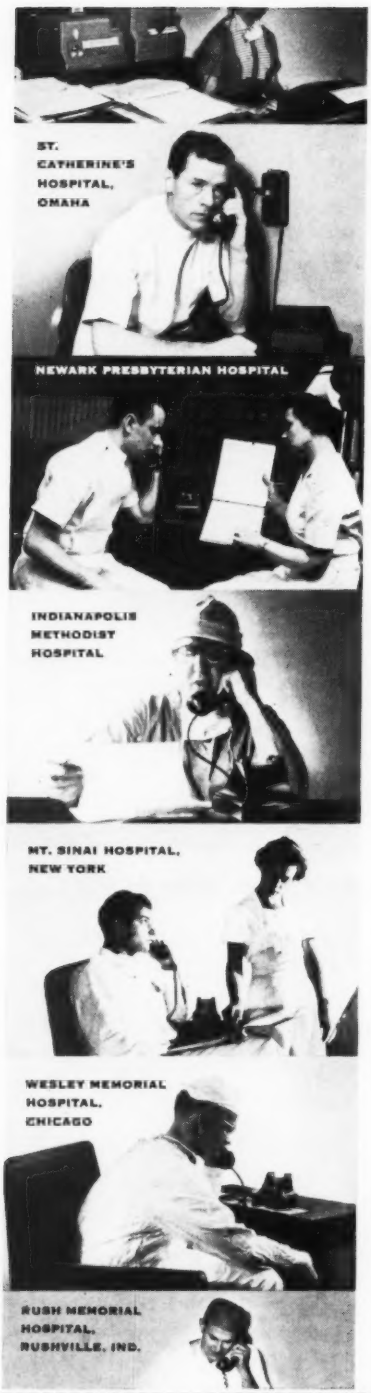
Aluminum
Rebecca Model #3204-A

Stainless Steel
Miles Model #1249-S

Our new enlarged 1954 Catalog is now ready. If you haven't received yours, drop us a postal card. We will mail it at once.

WILSON Stainless Steel and Welded Aluminum Alloy Equipment
MANUFACTURING CO. ★ COLUMBUS, GEORGIA

The name **WILSON** means—the highest quality materials and the most modern manufacturing methods have been used . . . and on all operating room equipment, the finest type casters—ball bearing, soft rubber, noiseless, electrically conductive.



THIS YEAR HUNDREDS OF HOSPITALS ARE GETTING BETTER, FASTER RECORDS WITH TELEVOICE!

Have You Looked Into It Yet?

Modern TELEVOICE phone dictation gives hospitals clear, complete records in ⅓rd the time! In hospital after hospital, EDISON TELEVOICE is providing accurate, typewritten records working for the patients' welfare hours sooner! Reports are dispatched at handy phone stations *immediately* after examining, treating, operating . . . they're current, complete, and easily *talked* while the facts are fresh. TELEVOICE ends time-wasting written work! Your MRL will welcome it! Investigate.

EDISON TELEVOICE

For Better Medical Records

Get the full story!

Here, in this new, 8-page, illustrated folder, are the facts on TELEVOICE. You'll see how high-speed TELEVOICE service can be applied throughout your hospital. You'll read what other hospital authorities say about TELEVOICE. Just send coupon for "The *New*-Fashioned Way to BETTER MEDICAL RECORDS." There's no obligation.

EDISON *(Ediphone Division)*
10 Lakeside Ave., West Orange, N. J.

Please send me "The *New*-Fashioned Way to BETTER MEDICAL RECORDS."

NAME_____ TITLE_____

HOSPITAL_____

ADDRESS_____

CITY_____ ZONE____ STATE_____

What's New . . .

Fast Action Collator for Table Top Operation

Fast action and smooth, dependable operation are offered in the improved Thomas Table Top Collator. The new unit employs the tilted bins, Ejectomatic Feed and ball bearing mechanism found in large floor models. Pages to be collated are stacked into bins and the collating cycle is controlled by a hand lever which can be located on either the right or the left side of the unit. Rubber tipped "fingers" push the top sheets of each stack into the operator's hand. All papers are always before the operator for constant inspection.

The table unit occupies only 16 by 27 inches of desk space and is available in both five and eight bin capacities. **Thomas Collators, Inc., 30 Church St., New York 7.**

For more details circle #341 on mailing card.

Plastic Tumblers Are Transparent and Strong

Molded of a high heat-resistant, nontoxic plastic, the new Bolta Tumblers are designed to reduce breakage costs, to withstand constant dishwashing and sterilizing, and to be attractive in appearance. They are light in weight and easy to handle, yet have sufficient body to keep them in place in dishwasher racks. They are smooth at the rim, have no rough edges and are molded in a graceful fluted design. The new tumblers are available in 5, 8½ and 12 ounce sizes. **Bolta Co., Food Service Equipment Div., Lawrence, Mass.**

For more details circle #342 on mailing card.

Cooked Food Kept Fresh in New Warmer

The Vulcan-Hart Roll and Food Warmer is designed to keep cooked food oven fresh and ready for instant serving, even though prepared well in advance. The warmer is made in two, three and four drawer models, thermostatically controlled for uniform temperature. It is easily installed and ready for use when plugged into an electric outlet. The warmers are constructed of stainless steel and are easily cleaned. **Vulcan-Hart Manufacturing Co., 2006 N. Western Parkway, Louisville 3, Ky.**

For more details circle #343 on mailing card.

Eighty-Eight Typewriter Offers Improved Performance

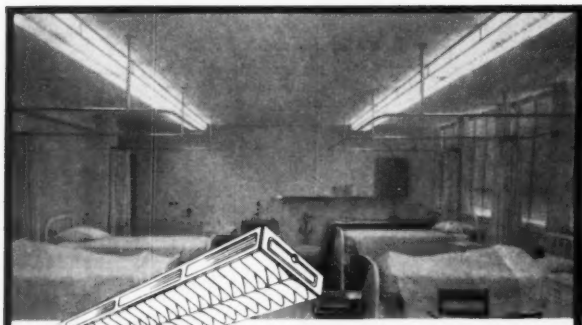
There are many new features offered in the Smith-Corona Eighty-Eight Secretarial Office Typewriter. The new model has all new action and construction, resulting in improved performance, according to the manufacturer. It is easy to operate with less effort, is responsive, speedy, and attractive in appearance.

Among the features of the new machine are the instant-set margins which operate with a touch. Platens are quickly and easily interchanged for special jobs. Two extra keys have been added to give

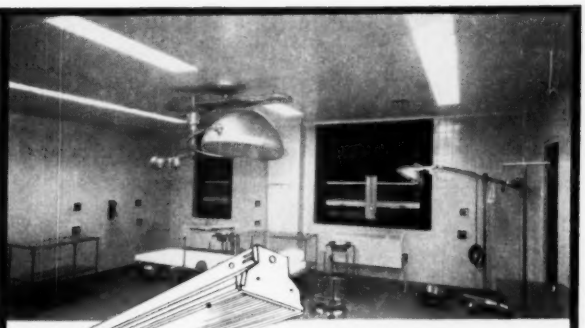
four additional useful symbols, without distortion of the standard keyboard. Keys are green and shaped to the fingers for speed and accuracy. The new machine is a compact efficient unit. **Smith-Corona Inc., Syracuse 1, N.Y.**

For more details circle #344 on mailing card.

(Continued on page 240)



DAY-BRITE PLEXOLINE® lights a nurse's training classroom. The problem solved here was the creation of high level general illumination without glare. PLEXOLINE does an equally good job in administrative offices and waiting rooms.



DAY-BRITE RECESSED "TROFFERS" in this operating room supply general lighting at all times and, during operations, eliminate dangerous brightness contrast between intense local lighting at the operating table and the surrounding area.

How to solve specific hospital lighting problems with

DAY-BRITE

These are actual Day-Brite hospital installations . . . each a "best buy" answer to one of the many lighting problems in your highly specialized field.

DAY-BRITE BED LAMPS are made specifically for patient room lighting. There's comfort and convenience here for the patient—direct light for reading, indirect light for general use. Sparkling stainless steel finish is easy to keep clean.

DAY-BRITE CFI DAY-LINE® industrial fixtures handle a man-sized lighting chore in a central kitchen. Here, as in other service areas, these rugged CFI's resist vibration, fumes and moisture, give you top performance under toughest conditions.

DAY-BRITE EXIT SIGNS mark emergency exits, direct corridor traffic in a large hospital. Doubly dependable, these trim, handsome Exit Signs are equipped with two sockets for continuous operation in the event one lamp fails. UL approved.

428

What makes Day-Brite a "best buy" investment for hospital lighting? We suggest the one best answer to that question is: LOOK AT DAY-BRITE YOURSELF... *FEEL* THE DIFFERENCE... BEFORE YOU BUY. Experience has taught us that your personal judgment of Day-Brite fixtures is the most convincing sales story we have.

We'll be happy to hear from you about your special problems, send you literature, arrange demonstrations any time you say. Mark your calendar now to write us or to see your local electrical contractor in the next few days.

"DECIDEDLY BETTER"
DAY-BRITE
Lighting Fixtures

Day-Brite Lighting, Inc., 5455 Bulwer Ave., St. Louis 7, Mo. In Canada: Amalgamated Electric Corp., Ltd., Toronto 6, Ontario.

SEE YOUR LOCAL ELECTRICAL CONTRACTOR

6 reasons why

SEMPRA

INTERCHANGEABLE SYRINGES MEAN

Longer Life
Superior Performance
at no extra cost!

1 **Longer Lasting Ground Surfaces!** Natural, or clear, glass has a wavy, uneven surface. Micro-precision gauging will indicate this condition. Precision grinding corrects it. And SEMPRA's precision grinding sires smo-o-o-ther action between the interfaces of the barrel and plunger.

2 **Universally Interchangeable!** The micro-precision grinding of SEMPRA INTERCHANGEABLE syringes make universal interchangeability possible. This feature is found only in SEMPRAs.

3 **Continued Interchangeability!** Seven years' field experience proves the longer SEMPRA's are used, the better they become—given reasonable care. Long service improves the ice-hard, silky-slick finish on barrel and plunger so that after years of service they still interchange and still meet Federal specifications.

4 **Parallel Sides!** Only parallel sides assure you freedom from constriction. And parallel sides are possible only in a syringe where both barrel *and* plunger have ground glass surfaces.

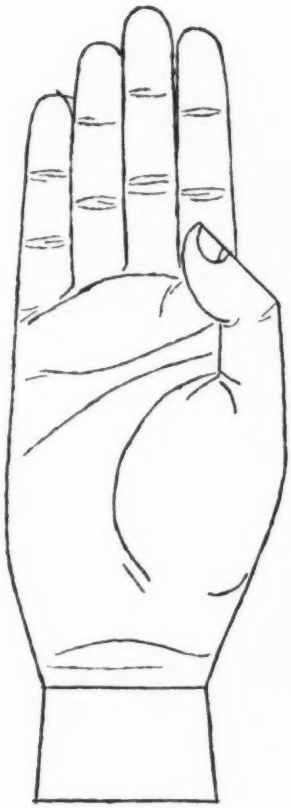
5 **Longer Life!** SEMPRA's ground glass surfaces are free of scratches, consequently alkalis, frequently present in sterilizing media, get no foothold to cause dangerous pits.

6 **Accurate Dosage!** Because SEMPRA's are universally interchangeable, they conform to only one set of tolerance specifications, therefore they're uniform in volume.

For a trial, get a supply of 2cc SEMPRA's on our money back guarantee. See for yourself why more hospitals each month are ordering SEMPRA's, the original interchangeable syringe. From your dealer, or write direct.

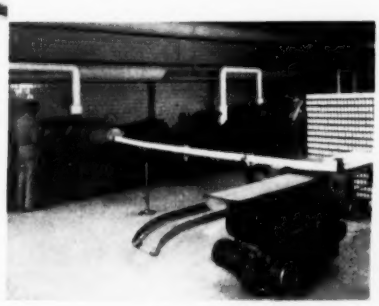
J. BISHOP & CO. Platinum Works
Medical Products Division
MALVERN PENNSYLVANIA

MORE DOCTORS ADVISE IVORY THAN ANY OTHER SOAP!



Women here soak their left arms in one soap solution and right arms in a second soap solution. After a measured interval the arms are examined to compare the effects of various soaps on the skin.

Ivory Purity



One of a battery of mechanical freezers at work turning out an endless bar of pure Ivory Soap.

The blue and white wrappers are "Rolled on" in this miraculously speedy wrapping machine.

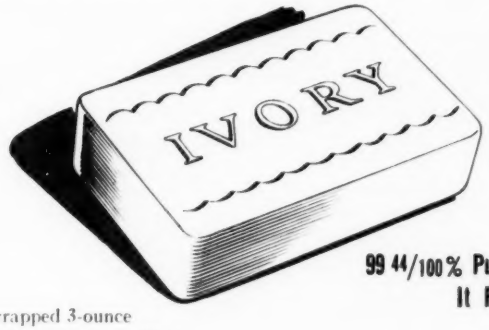
• • AS ZEALOUSLY SAFEGUARDED AS YOU SAFEGUARD HUMAN LIFE • •

Every possible precaution is observed in the making of Ivory Soap to maintain its justly famed purity.

To you who minister to suffering humanity—using every safeguard that science and medical skill make available—this fact should be of particular significance.

For it means that you can trust Ivory always. Trust it to perform as a fine soap should perform in cleansing the skin thoroughly, safely, agreeably.

The fact that Ivory has long been the most widely accepted soap in countless fine hospitals offers convincing proof that its fine qualities are fully appreciated. Is yours an Ivory hospital?



99 44/100% Pure—It Floats

Procter & Gamble
CINCINNATI, OHIO

Ivory Soap in the popular unwrapped 3-ounce size (packed weight) is available for hospital use. There are four smaller sizes, too—wrapped or unwrapped.

What's New . . .

Console Air Conditioner in Three Sizes

The Modine Airditioner is a new console type air conditioner designed for the cooling, heating and ventilating of individual rooms. It is available in three sizes with nominal cooling capacities of ¾, 1½ and 2 tons. Installation requires connection only to water supply and return and drain. Chilled water is used for cooling, hot water for heating, and fresh outside air for ventilation is introduced through an aperture in the rear of the unit. A manually operated damper is adjusted to control the mixture of fresh and recirculated air.

The attractive cabinet is finished in Marine Green baked-on primer which has high resistance to moisture. It is suitable for use without further finishing, or can be finished to match room decorations. The unit can be adapted to either fully exposed or partially recessed installation. **Modine Manufacturing Co., Racine, Wis.**

For more details circle #345 on mailing card.

Baskets and Hampers of Cotton and Steel

Sturdy, long lasting baskets, trucks and hampers for use in the hospital laundry, linen rooms, housekeeping service and other departments have recently been introduced. All-steel frames hold the strong, sturdy canvas used to form the baskets. The Cottonblossom line is long lasting and is especially suited to hard usage. More than a dozen varieties and sizes of trucks, baskets and hampers are available in the new line. The canvas is easily laundered and returned to the frame for use. **Southern Mills, Inc., 585 Wells S. W., Atlanta, Ga.**

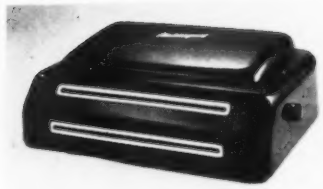
For more details circle #346 on mailing card.

Printer and Developer Combined in Photocopy Unit

The Photorapid is a one-unit photocopy machine which combines printer and developer. The compact unit for desk operation produces exact copies of any material, whether on one or both sides, opaque or translucent, white or colored. Single side or double side copies can be made as well as transparent and tissue copies. Pages from bound books can be copied without injuring or removing the pages.

The machine measures 16½ by 23½ inches with developer tray which is removable for cleaning and a lid that closes

(Continued on page 244)



tight when not in use, to preserve the solution. The Photorapid is of non-metallic construction, finished in black with white trim. It is easily operated, even by unskilled help. **Copy-Craft, Inc., 105 Chambers St., New York 7.**

For more details circle #347 on mailing card.

Power Leaf Mill Eliminates Leaf Raking

A new machine has been introduced for care of grounds which eliminates the need for leaf raking. The Turbo Jet Power Leaf Mill simplifies the problem of maintaing large grounds as it gathers and pulverizes fallen leaves, blowing the fine chaff back into the lawn as a mulch.

The Turbo Jet is easy to operate and will also clean leaves out of ivy beds and shrubs, from around curbs, copings and fences, and other difficult locations. **The Turbo Jet Mfg. Co., 22 Bowman Terrace, Cincinnati 29, Ohio.**

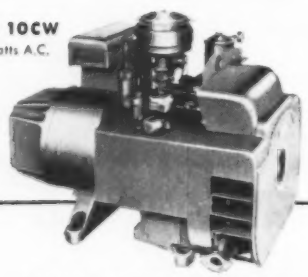
For more details circle #348 on mailing card.

Rate Your Hospital on Standby Power Protection

Standby Power Check Chart for Essential Services and Equipment

	Protected	Not Protected
• Operating Room	☐	☐
• Delivery Room	☐	☐
• Hall and Stair Lighting	☐	☐
• X-Ray Equipment	☐	☐
• Heating System	☐	☐
• Elevators	☐	☐
• Ventilation	☐	☐
• Communications	☐	☐
• Respirators	☐	☐

MODEL 10CW
10,000 watts A.C.



WHAT WILL COMPLETE PROTECTION COST?

Onan's wide range of sizes and models . . . from 1,000 to 50,000 watts . . . permits you to choose the plant that fits *your* capacity requirements *exactly* . . . keeps cost in line with the need. Let us know what equipment must be operated by emergency electricity; we will recommend the size plant you need and estimate the cost.

MODEL 25HN
25,000 watts A.C.

ONAN Electric Plants guard all essential services

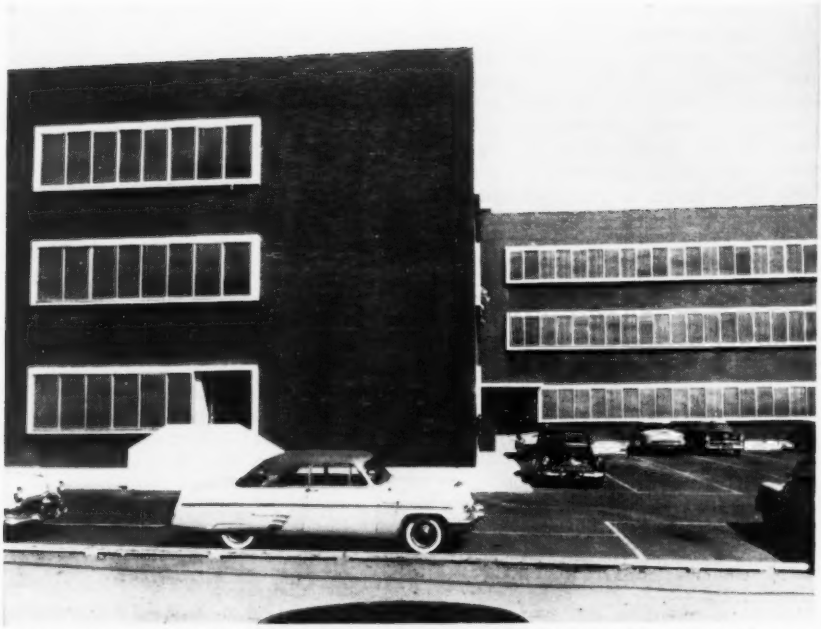
If the check-chart above shows standby power for operating and delivery rooms *only*, your hospital may be inadequately protected. Interruption of *any* important hospital service because equipment can't be operated, may endanger lives. Property too may suffer damage.

Onan Emergency Electric Plants, available in sizes up to 50,000 watts, have the capacity to operate whatever you decide is essential . . . elevator, automatic heating system, ventilators, X-ray machines, communications, lighting and other equipment. All Onan standby units can be equipped with controls which start the electric plant automatically when power is interrupted and stop it when power is restored.

Onan ELECTRIC PLANTS

Write for special folder on standby electric power for hospitals

D. W. ONAN & SONS INC.
4941 University Avenue S. E. • Minneapolis 14, Minnesota



ON 8820 WILSHIRE MEDICAL BUILDING, Kaiser Aluminum Shade Screening keeps rays of hot sun outside windows.

ABOVE—Before Shade Screening, hot sun rays flooded through windows. **BELOW**—With Shade Screening installed, glare is eliminated, increasing comfort of patients.

Medical Building beats hot sun

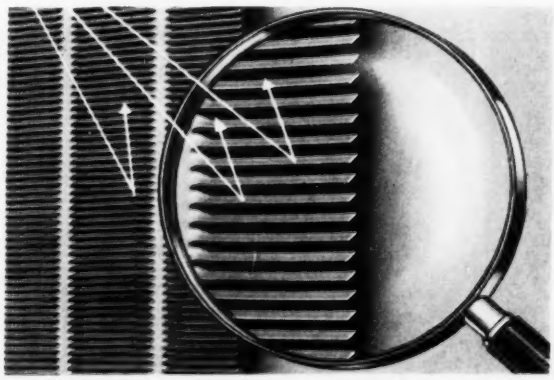
with Kaiser Aluminum Shade Screening!

THE 8820 Wilshire Medical Building is another of many medical institutions now enjoying the benefits of revolutionary Kaiser Aluminum Shade Screening.

On buildings of *any* type, Kaiser Aluminum Shade Screening is an amazingly effective cooling device—with a combination of advantages no other screening can match. Among these advantages are:

1. **Keeps interiors as much as 15° cooler,** in hottest summer sun!
2. **Increases air conditioning efficiency** by reducing "peak" loads. Where air conditioning exists, operating costs are cut! Where it is planned, smaller units can be used.
3. **Protects against sun fading** of interior furnishings.
4. **Cuts harsh glare.** Yet admits plenty of soft light. Air circulates freely.
5. **Maintenance-free!** Precision-produced from tough, high-grade aluminum. Never needs paint. Corrosion-resistant. Can be left up the year round.
6. **Protects against insects!** Screens out insects like any standard screening.
7. **Gives daytime privacy.** You can see out, but outsiders' view is blocked.
8. **Enhances appearance** of any style building. Simple design and construction make it a favorite with architects.

If you have a sun problem in your hospital or medical building it will pay you to investigate Kaiser Aluminum Shade Screening *now*.



How revolutionary Kaiser Aluminum Shade Screening works: Thousands of tiny horizontal louvers are permanently slanted at a downward angle deflecting hot sun rays *before* they hit windows. This removes a major cause of high temperatures. Interiors stay as much as 15° cooler! Shading devices inside windows are of little value, because once sun heat passes through windows, it is trapped.

For free sample demonstrator and complete information, mail coupon today! For names of your nearest suppliers and applicators, contact the Kaiser Aluminum Sales office listed in your telephone directory.

Kaiser Aluminum

PATENTED

SHADE SCREENING

KAISER ALUMINUM & CHEMICAL SALES, INC.
Consumer Service Division
556 Kaiser Bldg., Oakland, California

Name_____

Address_____

City_____ State_____

What's New . . .

Pharmaceuticals

Combandrin and Combandrets

Combandrin and Combandrets contain both male and female hormones in combination. They are indicated in the treatment of the male and female climacteric, osteoporosis, and for their combined hormonal protein anabolic effects. They are said to assist in restoring a sense of good health and constitutional well-being in patients over fifty. Combandrin is given by deep intramuscular injection. Combandrets are designed for buccal administration. **Chas. Pfizer & Co., Inc., 630 Flushing Ave., Brooklyn 6, N. Y.**

For more details circle #349 on mailing card.

Tetracyn

A new board-spectrum antibiotic,Tetracyn brand of tetracycline hydochloride shows true broad-spectrum activity against common infections, according to the reports. It has high tolerance, antopathogen range, stability and solubility. Supplied in sugar coated Tetracyn Tablets, it is available in 250 mg. in bottles of 10 and 100; in 100 mg. in bottles of 25 and 100, and in 50 mg. in bottles of 25 and 100. It is also available as Tetracyn Intravenous in vials of 250 and 500 mg. **J. B. Roerig and Company, 536 Lake Shore Drive, Chicago 11.**

For more details circle #350 on mailing card.

Bardase

Bardase is a new drug preparation for the treatment of visceral and smooth muscle spasm. It may be used for irritable colon, ulcerative colitis, peptic ulcer, genitourinary disturbances and dysmenorrhea. It is supplied in sugar-coated tablets, each containing 1/6 grain extract Belladonna, ¼ grain phenobarbital and 2½ grains Taka-Diastase. **Parke, Davis & Co., Detroit 32, Mich.**

For more details circle #351 on mailing card.

Ethobral Capsules

A triple barbiturate in capsule form is offered in the new Wyeth Ethobral Capsules. Each capsule contains ¾ gr. sodium secobarbital, ½ gr. sodium butabarbital and ¾ gr. phenobarbital. It is an improved hypnotic providing prompt action, sustained sleep for six to eight hours with virtually no sedative hangover. The product is available in bottles of 100 and 500 capsules. **Wyeth Incorporated, 1401 Walnut St., Philadelphia 2, Pa.**

For more details circle #352 on mailing card.

Pernaemon (PL)

Pernaemon (PL) is a U.S.P. refined liver extract for parenteral administration. It is prepared from pregnant mammalian livers which take on added functions. The extractable factors present in the pregnant liver are captured in Pernaemon (PL). The product is indicated for the treatment of pernicious anemia and for other conditions requiring injectable liver. It is supplied in 10 cc. multiple dose vials. **Organon Inc., Orange, N.J.**

For more details circle #353 on mailing card.

Dramcillin-300 Suspension

A newly developed, highly palatable, oral dosage form of potassium penicillin G is offered in White's Dramcillin-300 Suspension. It is a stable, ready-to-use, creamy suspension which retains its potency for long periods without refrigeration. Each teaspoonful (5 cc.) contains 300,000 units of penicillin G potassium. It is supplied in bottles of 60 cc. **White Laboratories, Inc., Kenilworth, N.J.**

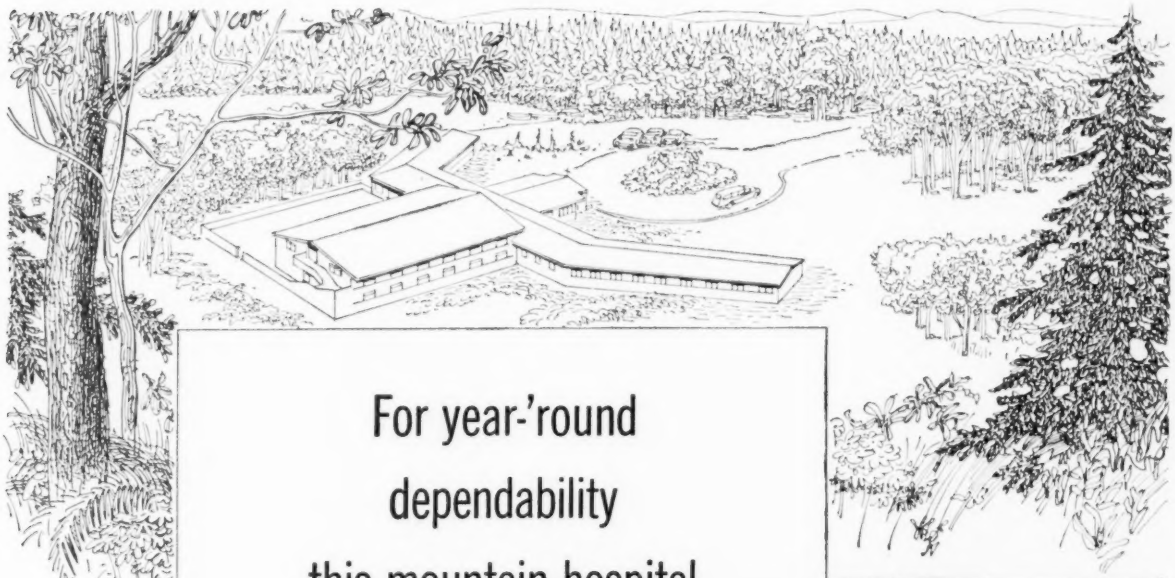
For more details circle #354 on mailing card.

Rautensin

In addition to dropping the blood pressure moderately, Rautensin Tablets are said to lead to striking subjective improvement in the patient with essential hypertension. Each Rautensin Tablet contains 2 mg. of the alseroxylon fraction of Rauwolfia serpentina. It is said to suffice as the sole therapeutic agent in mild, moderate and labile hypertension. **Smith-Dorsey, Lincoln, Neb.**

For more details circle #355 on mailing card.

(Continued on page 248)



For year-'round dependability this mountain hospital relies on *GAS*

At the Santa Anita Hospital, located a mile high in the quiet beauty of the San Bernardino Mountains, Gas Cooking gives the food they serve the best nutritional values plus a big extra . . . the taste appeal of appetizing appearance.

In any hospital, but especially one in a location as remote as this, the problem of fuel *supply* is important, also. Here again Gas is the preferred cooking medium, for it is both dependable and economical. The continuous flow of Gas has not been interrupted by the heavy snow storms of the area, and the cost for this steady supply of fuel is no greater than if the hospital were located within the city limits of Los Angeles.

There are many other advantages, too, that make Gas the preferred cooking fuel for all hospital requirements. Gas Cooking is clean, fast, dependable efficient . . . and versatile, to meet the exacting demands of hospital service.

Ask your Food Service Equipment Dealer or Gas Company Representatives for full details on how Gas and Modern Gas Equipment fulfills every hospital cooking need.

AMERICAN GAS ASSOCIATION

420 LEXINGTON AVENUE, NEW YORK 17, NEW YORK

MORE AND MORE THE TREND IS TO GAS

Don't be fooled by Fast Action Cleaners

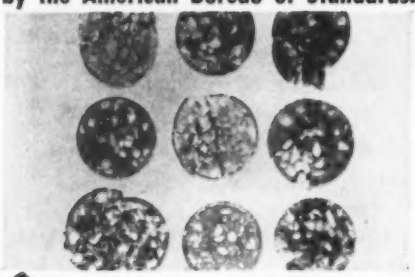
You can't judge a cleaner by fast wetting alone. When harmful ingredients are added to increase the speed of cleaning . . . you also increase maintenance costs—you sacrifice the beauty and appearance of your floor. Because harsh so-called fast wetting cleaners work by ATTACKING soil AND your floors. They not only remove dirt and grease, but relentlessly wear away the floor surface; rob resilient floors of natural oils, causing them to become brittle, colors to bleed; build up a crystalline expansion in cement and terrazzo causing untimely deterioration. Due to the roughing and pitting of the surface, floors become increasingly harder to clean each time, and labor costs go up.

That's why Hillyard SUPER SHINE-ALL has no equal in the cleaning field. Its superior cleaning power, by safe neutral chemical action, has been proved non-injurious to finest floors or finishes. It is the result of nearly 50 years specialization in making cleaning a faster, safer, less expensive operation. Through the years it has won the approval of the Asphalt Tile Manufacturers, Rubber Tile Manufacturers, Cement and Terrazzo Contractors, Portland Cement Companies, Maple and Oak Flooring Manufacturers.

That's why—year after year, SUPER SHINE-ALL proves to be *your* best cleaning buy.

How Improper Cleaners Ruin Terrazzo and Cement

Photos show results of Tests conducted over a 4-year period by the American Bureau of Standards.



Terrazzo disks on which cleaners containing soda ash and trisodium phosphate were used. Test applies equally to cement. Note damaging action which has occurred in the porous cement.

Terrazzo disks on which a neutral chemical cleaner was used, remain in perfect condition. The National Terrazzo and Mosaic Foundation states . . . "soaps and scrubbing powders containing caustic alkali should never be used in maintenance of terrazzo . . . use a *good neutral cleaner*."

Mayo Clinic Diagnostic Building, Rochester, Minn.
Architects: Ellerbe & Company, Minneapolis, Minn.
General Contractor: O. A. Stocke & Company, Inc., Rochester, Minn.

Diagnosis: NOISE. Perfect Rx: QUIET

Of all public buildings of all types, the hospital is obviously among those that most require an atmosphere of near-complete silence. Yet hospital clinic or ward can be at the top of the list in failing to meet this need. Noise of routine activity in corridors and rooms has a disturbing, recovery-retarding effect on patients, cuts efficiency of the working staff.

A sure antidote, however, is Acousti-Celotex Sound Conditioning . . . such as the complete treatment given the beautiful new Mayo Clinic Diagnostic Building. Here, Acousteel and Perforated Mineral Fiber Tile were used in the majority of installations with remarkable results. In elevator lobbies like the one shown above, Celotone®, spray-painted dark green, was installed to control traffic noise and provide a dramatic textured quality for ceiling areas.

Low-Cost Answer

A sound-absorbing ceiling of Acousti-Celotex Tile has been found the economical answer in hundreds of the nation's hospitals. The gratifying effect is that noise is checked at the very outset . . . in wards, clinics, operating and delivery rooms, nurseries, private rooms, corridors, lobbies, kitchens, utility rooms. And the resultant *soothing quiet* lends to patients' hastened recovery, and to the heightened working efficiency of hospital personnel.

Easy Maintenance

Quickly installed, Acousti-Celotex Tile requires no special maintenance. Its unique surface provides beauty combined with high sound-absorption value. And it can be washed *repeatedly* and painted *repeatedly* with absolutely no loss of its sound-absorbing properties.

Mail Coupon for a Sound Conditioning Survey Chart that will bring you a *free analysis* of the noise problem in your hospital, plus a free factual booklet, "The Quiet Hospital." There is no obligation.

TRADE MARK

ACOUSTI-CELOTEX

REGISTERED U. S. PAT. OFF.

Sound Conditioning

Products for Every Sound Conditioning Problem—The Celotex Corporation, 120 S. La Salle St. Chicago 3, Illinois • In Canada: Dominion Sound Equipments, Ltd., Montreal, Quebec

Mail Coupon Now!

The Celotex Corporation, Dept. G-54
120 S. La Salle St., Chicago 3, Illinois

Without cost or obligation, please send me the Acousti-Celotex Sound Conditioning Survey Chart, and your booklet, "The Quiet Hospital."

Name_____ Title _____

Address_____

City_____ County_____ State_____

What's New . . .

Product Literature

• How to select the right product for each cleaning purpose is discussed in the new **"Soap and Synthetic Detergent Buying Guide"** issued by Colgate-Palmolive Company, 105 Hudson St., Jersey City 2, N.J. Economies in time, effort and money can be effected through a study of the material which covers the complete line of cleaning products in a compact, pocket sized booklet.

For more details circle #356 on mailing card.

• **Barber-Colman Electronic Hot Water Controls** are discussed in **Bulletin F 6167** issued by Barber-Colman Company, Rockford, Ill. The catalog describes the flexibility of these controls and gives information on the use of optional night depression with morning warm-up features.

For more details circle #357 on mailing card.

• How stone structures can be restored without damage to the face of the stone is discussed in an eight page folder, **"Maintenance and Restoration of Stone Structures,"** issued by Western Waterproofing Co., Inc., 1220 Syndicate Trust Bldg., St. Louis 1, Mo. How the Wet-Aggregate Cleaning Process is used is discussed and photographs of actual buildings and close-ups of stone facing illustrate the text.

For more details circle #358 on mailing card.

• A new bulletin on electric stopwatches has just been published by the Prescision Scientific Company, 3737 W. Cortland St., Chicago 47. **Bulletin No. 646** fully describes the redesigned "Time-It" electric stopwatch in both the Minute Model and Second Model with illustrations to explain the indicating counter.

For more details circle #359 on mailing card.

• **"Owens Illinois tells . . . The Kimble Glass Story"** is the title of an attractive booklet, with black covers printed in white and bound in white plastic to lie flat when opened. The booklet, issued by Kimble Glass Company, Subsidiary of Owens-Illinois Glass Company, Toledo 1, Ohio, tells the story in words and pictures, of Kimble Laboratory Glassware, Color-Break Ampuls, Insulux Glass Blocks, Thermometers, Light-Directing Glass Blocks and other Kimble Glass products.

For more details circle #360 on mailing card.

• **"How to Care for Your Floors"** is the subject of a new booklet, giving "How to" suggestions for floor care, brought out by S. C. Johnson & Son, Inc., Racine, Wis. The material tells how to finish all types of floors, how to cure sick floors, how to make floors safer to walk on, how to choose right products for floors and tips on day-by-day maintenance.

For more details circle #361 on mailing card.

(Continued on page 250)

• An explanation of how silicones work is given in a new technical brochure describing the **theory, application and benefits of resin water-repellent compounds** for above-grade masonry. Offered by the Construction Specialties Division, Dewey and Almy Chemical Company, Cambridge 40, Mass., the brochure also shows how such water repellents reduce maintenance costs and preserve structures from water damage, leakage and weather.

For more details circle #362 on mailing card.

• The new 32 page **catalog of Hospital Expendables** offered by the Hospital Division of Clark Linen and Equipment Co., 303 W. Monroe St., Chicago 6, is devoted entirely to merchandise used in everyday operation of a hospital. The booklet can be used separately as a reference for hospital supplies, and in conjunction with the company's 328 page catalog listing the full line of linens, supplies, equipment and furniture available to hospitals.

For more details circle #363 on mailing card.

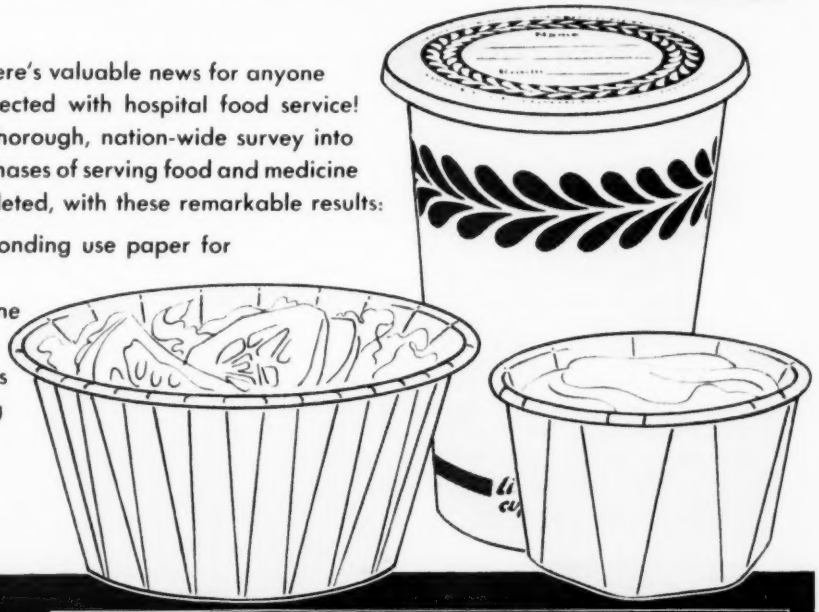
• **"The Gendron Story"** is the title of a new sound slide film issued by the Gendron Wheel Company, Perrysburg, Ohio. The 17 minute presentation presents the history and current production methods of the Gendron line of hospital equipment and wheel chairs.

For more details circle #364 on mailing card.

WHAT DID A SURVEY OF PAPER CUPS AND CONTAINERS IN HOSPITALS PROVE?

Here's valuable news for anyone connected with hospital food service! A thorough, nation-wide survey into all phases of serving food and medicine in hospitals has just been completed, with these remarkable results:

- Over 70% of hospitals responding use paper for food service!
- Over 74% use paper for one or more medical uses!
- Since World War II, hospitals have used an ever-increasing number of paper cups and containers for more and more purposes!

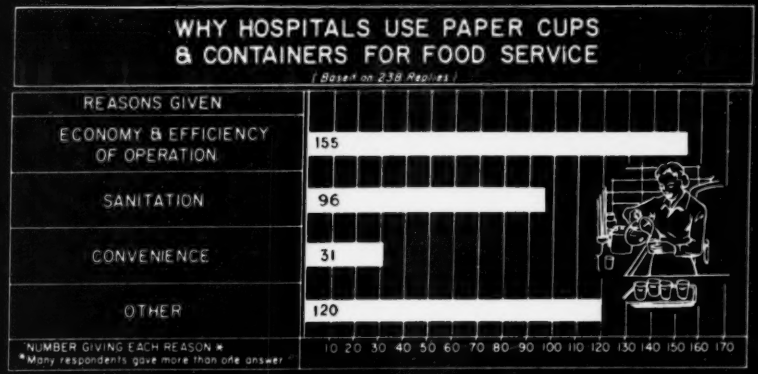


The reasons for this great swing to paper are shown in the chart. They're as simple as A, B, C:

(A) — Increased economy and efficiency of operation!

(B) — Greater safety and sanitation!

(C) — Convenience!



As you consider the advantages of paper service in your hospital — consider this: Lily* Paper Service provides a complete, sturdy, attractive hospital food service including cups, containers, plates and tray mats in the popular matched green leaf design.

Our free "Hospital Food Service" kit contains samples and full details. Just mail the coupon and we'll send it — without obligation!

*T.M. Reg. U.S. Pat. Off.

LILY-TULIP CUP CORPORATION

122 East 42nd Street, New York 17, N. Y.

Chicago • Kansas City • Los Angeles
San Francisco • Seattle • Toronto, Canada

Lily-Tulip Cup Corporation, 122 E. 42nd St., N. Y. 17, N. Y. MH-5

Yes, I'd like to receive your "Hospital Food Service" kit plus full information on Lily Paper Service for the hospital.

Name.....

Name of Hospital.....

Address.....

City.....Zone....State.....

What's New . . .

• **"Planning A Dishwashing System"** is the title of a leaflet released by Universal Dishwashing Machinery Co., 35 Windsor Place, Nutley 10, New Jersey. The story gives detailed information on the advantages and disadvantages of having a dishwashing system and lists the five types of dishwashing machines from which the most suitable in size and type of operation may be selected.

For more details circle #365 on mailing card.

• A new 20 page catalog of **instruments for radiation measurement** has just been announced by The Victoreen Instrument Company, Medical Instruments Division, 5806 Hough Ave., Cleveland 3, Ohio. The booklet contains descriptive data, illustrations and technical specifications for medical X-Ray control, personnel dosimeters, health survey and isotope laboratory instruments and accessories.

For more details circle #366 on mailing card.

• **"Fire Can Destroy Your Business"** is the subject of the new eight page **bulletin No. 2426** published by The Automatic Sprinkler Department of Blaw-Knox Company, 829 Beaver Ave., Pittsburgh 33, Pa. The bulletin discusses the various types of systems such as water, fog, foam, and carbon dioxide, and illustrations are shown of the new spray sprinkler and other devices developed by the company.

For more details circle #367 on mailing card.

• A 30 page booklet on **IBM Accounting for Hospitals** has been issued by International Business Machines Corp., 590 Madison Ave., New York 22. The method supplies management control reports backed by detailed accounting and statistical records, as well as complete financial and cost statements and specific information about individual department operations. All of this is described in the illustrated booklet which is printed in editorial text form.

For more details circle #368 on mailing card.

• **"Aluminum - Jacketed Foamglas Pipe Insulation"** is discussed in a new bulletin offered by Pittsburgh Corning Corporation, 1 Gateway Center, Pittsburgh 22, Pa. Illustrated condensed specifications for the insulation of both hot and cold lines supplement information on the economies made possible by the new aluminum jacket.

For more details circle #369 on mailing card.

• **"How to Use Your FencPainteR"** is the title of a booklet issued by Fence Painter Corporation, 2314 W. Van Buren St., Chicago 12. Photographs and text tell the story of the FencPainteR, how it is used, the results obtained and the advantages of this fast, inexpensive and effective method of painting not only wire, iron, wood, stone and brick fences, but many other outdoor surfaces.

For more details circle #370 on mailing card.

• Detailed information on the **Royalmatic and Manual Nurse Saver** calling system is given in **Bulletin 213** released by The Standard Electric Time Company, 89 Logan St., Springfield 2, Mass. The material describes fully the equipment and operation of both systems and has diagrams to supplement the descriptive text.

For more details circle #371 on mailing card.

• A new illustrated **bulletin, No. 114,** giving detailed information on **Polyethylene Laboratory Ware,** has just been released by the Arthur H. Thomas Company, 230 South 7th St., Philadelphia 5, Pa. The material includes properties, applications, price lists and descriptions of 68 items in the line.

For more details circle #372 on mailing card.

• The story of **"Metropolitan Ceramic Glazed Structural Facing Tile"** is told in a 32 page booklet released by Metropolitan Brick, Inc., Canton, Ohio. Construction details and estimating data for this tile are given in the catalog which is illustrated by photographs and drawings. The center spread is printed in full color to show the attractive "Sight - Styled" Field Colors available. The brochure has a special section showing light reflection values for more than 40 different applications and 12 pages of shape drawings of the 6T and 4D series.

For more details circle #373 on mailing card.

(Continued on page 252)

"Sodas actually look and taste better..."

Libbey Heat-Treated Soda Glass in "Hi-Vision" Holder

Libbey "Hi-Vision" Service scores merchandising success at Owl Drug Co. fountains

ONLY after months of hard testing did the Owl Drug Company adopt Libbey "Hi-Vision" fountain service. That was more than three years ago! Is the company satisfied? We think Mr. Dow's letter speaks for itself. 62 Owl stores on the West Coast use "Hi-Vision" exclusively—to sell their tasty sodas "on sight," quietly, yet effectively.

You'll like the operating economies of Libbey "Hi-Vision" Service, too. The Heat-Treated tumblers are specially processed to withstand the knocks of hard, everyday usage. And each glass carries the money-saving protection of Libbey's "Safedge" guarantee: "A new glass if the rim of a Libbey 'Safedge' glass ever chips!"

For samples and prices of Libbey's "Hi-Vision" Service—or any of the many other tumbler items in the complete Libbey line—see your near-by Libbey Supply dealer. Or write to Libbey Glass, Division of Owens-Illinois, Toledo 1, Ohio.

THE OWL DRUG CO
8480 BEVERLY BOULEVARD
LOS ANGELES 48, CALIFORNIA

May 1, 1954

Libbey Glass
Toledo 1, Ohio

Gentlemen:

Libbey "Hi-Vision" fountain service has veritably put us back in the soda business. Customer acceptance of the glasses has gone far beyond our greatest expectations.

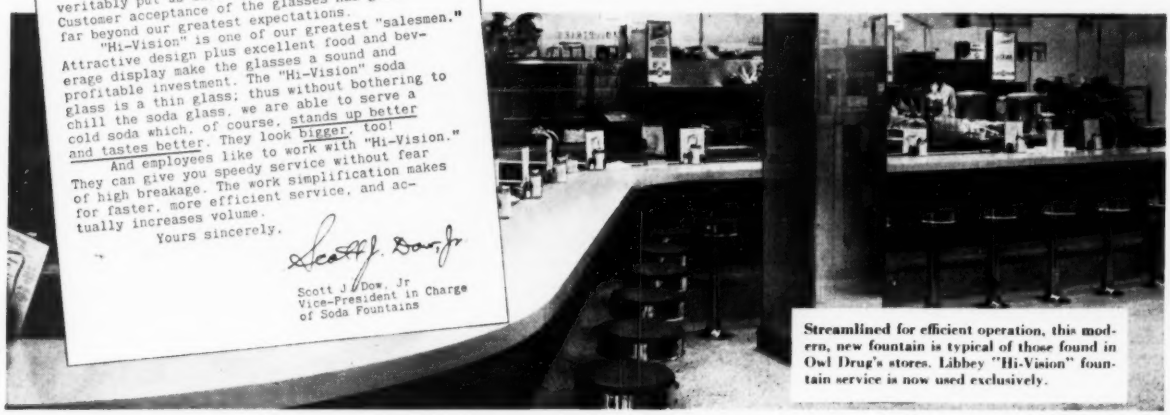
"Hi-Vision" is one of our greatest "salesmen." Attractive design plus excellent food and beverage display make the glasses a sound and profitable investment. The "Hi-Vision" soda glass is a thin glass; thus without bothering to chill the soda glass, we are able to serve a cold soda which, of course, stands up better and tastes better. They look bigger, too!

And employees like to work with "Hi-Vision." They can give you speedy service without fear of high breakage. The work simplification makes for faster, more efficient service, and actually increases volume.

Yours sincerely,

Scott J. Dow, Jr.

Scott J. Dow, Jr
Vice-President in Charge of Soda Fountains



Streamlined for efficient operation, this modern, new fountain is typical of those found in Owl Drug's stores. Libbey "Hi-Vision" fountain service is now used exclusively.

LIBBEY SAFEDGE GLASSWARE
AN (O) PRODUCT

OWENS-ILLINOIS
GENERAL OFFICES · TOLEDO 1, OHIO

What's New . . .

• **"Intravenous Anesthesia With Barbiturates"** is the title of a new medical motion picture produced under the joint sponsorship of the American College of Surgeons and the American Society of Anesthesiologists by Abbott Laboratories, North Chicago, Ill. The 16 mm. sound picture is produced in full color and has a running time of 30 minutes.

For more details circle #374 on mailing card.

• The entire line of mixed-bed, two-bed and four-bed demineralizers for hospital and laboratory use, available from Barnstead Still & Sterilizer Co., Forest Hills, Boston 31, Mass., is described in a 20 page catalog recently released. **Catalog No. 127** is illustrated with photographs, drawings and diagrams which supplement the descriptive text.

For more details circle #375 on mailing card.

• Attractive photographs are used in a folder from the California Darlington Company, 11702 Mississippi Ave., Los Angeles 25, Calif., to illustrate the complete facilities for patient care which are incorporated into "The Beem Bed." The accompanying text describes the operation of this completely engineered bed which incorporates bathroom facilities, head and knee lift, variable elevation from 23 to 32 inches from the floor, a self-contained hospital cart, retractable trapeze, and a self-contained adjustable tray with space for the patient's personal items. All of these facilities are within reach and are operated by finger-tip push-button control with the buttons immediately available to the patient.

For more details circle #376 on mailing card.

• A new **Sanymetal Suspended Ceiling Catalog SN-6** has been issued by Sanymetal Products Co., Inc., Suspended Ceilings Division, 2093 E. 19th St., Cleveland 15, Ohio. Advantages, engineering data and architectural specifications on two popular types of suspended ceilings systems, known as Nailock and Screwlock, are contained in the catalog. Both systems are designed for use with a wide variety of suspended ceiling and acoustical materials and provide a ready means of detachment of facing materials, with full salvage, when access is required for repair work or for remodeling.

For more details circle #377 on mailing card.

• A revised edition of **"Better Laboratory Planning,"** has been issued by the Scientific Apparatus Makers Association, 20 N. Wacker Drive, Chicago 6. A comprehensive approach to the better planning of laboratories is presented in the revised edition, based upon helpful comments from users of the original publication. New and attractive pictures of laboratories in colleges, hospitals, secondary schools and other institutions are presented and there is a helpful section on bidding.

For more details circle #378 on mailing card.

• **The Kewanee - Petro Boiler - Burner Catalog 502** tells the story of a unit which has been produced for either gas, oil, or oil and gas firing, for high or low pressure operation by Kewanne Ross Corp., Kewanee, Ill. Descriptive information on the boiler, which with supplemental equipment is all mounted on skids and assembled for the attachment of the firing equipment, is given in the catalog which also carries detailed information on the firing equipment and its assembling. Cut-away color photographs, charts and regular product photographs illustrate the descriptive text.

For more details circle #379 on mailing card.

• A new multi-colored **Catalog of Soap Dispensers, Valves and Tanks** has been issued by Bobrick Manufacturing Corporation, 1214 Nostrand Ave., Brooklyn 25, N.Y. The catalog is divided into sections for easy reference and includes information on capacity, dimensions and individual features of each model.

For more details circle #380 on mailing card.

• The complete line of syringes and other surgical specialties handled by Popper & Sons, Inc., 300 Fourth Ave., New York 10, is illustrated and described in a new catalog, **"Products for the Hospital, Laboratory, Physician."** The 60 page catalog is bound in a heavy cover to withstand constant use and is divided into six sections. A 16 page applicable price list for quick and easy reference is available with the catalog.

For more details circle #381 on mailing card.

• A new 92 page **catalog** of Labline equipment and apparatus for research and control laboratories is available from Labline, Inc., 217 N. Desplaines St., Chicago 6.

For more details circle #382 on mailing card.

• **How to Install a Rubber Tile Floor,** from the room diagram to the finished product, is covered in a new folder offered by the Rubber Flooring Division of The Rubber Manufacturers Association, 444 Madison Ave., New York 22. A chart on which to diagram the room and lay out the floor pattern is included with instructions on preparing the subfloor, installing the rubber tile and maintaining the finished floor.

For more details circle #383 on mailing card.

• The new line of auxiliary emergency lighting equipment recently announced by The Electric Storage Battery Co., Box 8109, Philadelphia 1, Pa., is described in a four page pamphlet known as **Form 4808.** The information is presented to assist architects, administrators, engineers, purchasing agents and others in the selection of emergency lighting equipment. Typical emergency lighting installations are illustrated and described with suggested specifications conforming to the recently revised National Electrical Code.

For more details circle #384 on mailing card.

• The complete line of anesthestic and endotracheal equipment available from The Liquid Carbonic Corp., 3100 S. Kedzie Ave., Chicago 23, is described in a new **Medical Gas Therapy Equipment Catalog** recently published.

For more details circle #385 on mailing card.

• Condensed but complete information on **Smithcraft "Area Illumination"** is given in a new 8 page catalog recently released by Smithcraft Lighting Division, 233 Everett Ave., Chelsea 50, Mass. The catalog is profusely illustrated with photographs and drawings and presents a "cross-index" of fluorescent lighting.

For more details circle #386 on mailing card.

Book Announcements

Brownell, "A Textbook of Practical Nursing," 4th Ed., 512 pp., $4.25. "Mayo Clinic Diet Manual," 2nd Ed., 247 pp., $5.50. O'Hara, "Psychology and the Nurse," 4th Ed., 313 pp., $3.50. Routh, "Laboratory Manual of Chemistry," 3rd Ed., 109 pp., $1.75, and "Fundamentals of Inorganic, Organic and Biological Chemistry," 3rd Ed., 418 pp., $4.00. Thompson, "Introduction to Microorganisms," 3rd Ed., 552 pp., $5.25. Villee, "Biology," 2nd Ed., 670 pp., $6.50. **W. B. Saunders Company, W. Washington Square, Philadelphia 5, Pa.**

For more details circle #387 on mailing card.

Suppliers' News

Gilbert Hyde Chick Company, 821 75th Ave., Oakland 21, Calif., manufacturer of hospital orthopedic and fracture equipment, announces removal of its branch office from **16 James St., Elberton, Ga.,** to larger quarters at **788 Ponce de Leon Ave., N.E., Atlanta, Ga.**

Eichenlaubs, 3501 Butler St., Pittsburgh 1, Pa., manufacturer of institutional furniture, announces the opening of a **contract furniture center.** Featuring room and group displays of institutional furniture and furnishings, the new center offers every phase of contract buying under one roof for the convenience of the purchaser.

W. & J. Sloane, 575 Fifth Ave., New York 17, announces the opening of a **Contract Division** under the management of **Harry M. Pearson.** The new division will combine the contract furnishings departments of the four main Sloane stores in New York, Washington, San Francisco and Beverly Hills.

Sperti Faraday, Adrian, Mich., manufacturer of sun lamps and ultra-violet equipment, as well as other scientific and recording material, announces the acquisition of **Cooper Hewitt Electric Company** of Hoboken, N.J. The new company will manufacture all types of tubes and bulbs involving gaseous discharge, as well as mercury vapor tubes.

USE THIS CARD

(We pay the postage)

This card is detachable and is provided for the convenience of our subscribers, and those to whom they pass their copies, in obtaining information on products and services advertised in this issue or described in the "What's New" Section. See reverse side.

May, 1954

Please ask the manufacturers, indicated by the numbers I have circled, to send further literature and information provided there is no charge or obligation.

WHAT'S NEW

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ADVERTISEMENTS

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NAME TITLE

INSTITUTION

ADDRESS CITY ZONE STATE

What's New . . .

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For more details circle #375 on mailing card.

• Attractive photographs are used in a folder from the California Darlington Company, 11702 Mississippi Ave., Los Angeles 25, Calif., to illustrate the complete facilities for patient care which are incorporated into "The Beem Bed." The accompanying text describes the operation of this completely engineered bed which incorporates bathroom facilities, head and knee lift, variable elevation from 23 to 32 inches from the floor, a self-contained hospital cart, retractable trapeze, and a self-contained adjustable tray with space for the patient's personal items. All of these facilities are within reach and are operated by finger-tip push-button control with the buttons immediately available to the patient.

For more details circle #376 on mailing card.

• A new **Sanymetal Suspended Ceiling Catalog SN-6** has been issued by Sanymetal Products Co., Inc., Suspended Ceilings Division, 2093 E. 19th St., Cleveland 15, Ohio. Advantages, engineering data and architectural specifications on two popular types of suspended ceilings systems, known as Nailock and Screwlock, are contained in the catalog. Both systems are designed for use with a wide variety of suspended ceiling and acoustical materials and provide a ready means of detachment of facing materials, with full salvage, when access is required for repair work or for remodeling.

For more details circle #377 on mailing card.

• A revised edition of **"Better Laboratory Planning,"** has been issued by the Scientific Apparatus Makers Association, 20 N. Wacker Drive, Chicago 6. A comprehensive approach to the better planning of laboratories is presented in the revised edition, based upon helpful comments from users of the original publication. New and attractive pictures of laboratories in colleges, hospitals, secondary schools and other institutions are presented and there is a helpful section on bidding.

For more details circle #378 on mailing card.

• **The Kewanee - Petro Boiler - Burner Catalog 502** tells the story of a unit which has been produced for either gas, oil, or oil and gas firing, for high or low pressure operation by Kewanne Ross Corp., Kewanee, Ill. Descriptive information on the boiler, which with supplemental equipment is all mounted on skids and assembled for the attachment of the firing equipment, is given in the catalog which also carries detailed information on the firing equipment and its assembling. Cut-away color photographs, charts and regular product photographs illustrate the descriptive text.

For more details circle #379 on mailing card.

• A new multi-colored **Catalog of Soap Dispensers, Valves and Tanks** has been issued by Bobrick Manufacturing Corporation, 1214 Nostrand Ave., Brooklyn 25, N.Y. The catalog is divided into sections for easy reference and includes information on capacity, dimensions and individual features of each model.

For more details circle #380 on mailing card.

• The complete line of syringes and other surgical specialties handled by Popper & Sons, Inc., 300 Fourth Ave., New York 10, is illustrated and described in a new catalog, **"Products for the Hospital, Laboratory, Physician."** The 60 page catalog is bound in a heavy cover to withstand constant use and is divided into six sections. A 16 page applicable price list for quick and easy reference is available with the catalog.

For more details circle #381 on mailing card.

• A new 92 page **catalog** of Labline equipment and apparatus for research and control laboratories is available from Labline, Inc., 217 N. Desplaines St., Chicago 6.

For more details circle #382 on mailing card.

• **How to Install a Rubber Tile Floor,** from the room diagram to the finished product, is covered in a new folder offered by the Rubber Flooring Division of The Rubber Manufacturers Association, 444 Madison Ave., New York 22. A chart on which to diagram the room and lay out the floor pattern is included with instructions on preparing the subfloor, installing the rubber tile and maintaining the finished floor.

For more details circle #383 on mailing card.

• The new line of auxiliary emergency lighting equipment recently announced by The Electric Storage Battery Co., Box 8109, Philadelphia 1, Pa., is described in a four page pamphlet known as **Form 4808.** The information is presented to assist architects, administrators, engineers, purchasing agents and others in the selection of emergency lighting equipment. Typical emergency lighting installations are illustrated and described with suggested specifications conforming to the recently revised National Electrical Code.

For more details circle #384 on mailing card.

• The complete line of anesthestic and endotracheal equipment available from The Liquid Carbonic Corp., 3100 S. Kedzie Ave., Chicago 23, is described in a new **Medical Gas Therapy Equipment Catalog** recently published.

For more details circle #385 on mailing card.

• Condensed but complete information on **Smithcraft "Area Illumination"** is given in a new 8 page catalog recently released by Smithcraft Lighting Division, 233 Everett Ave., Chelsea 50, Mass. The catalog is profusely illustrated with photographs and drawings and presents a "cross-index" of fluorescent lighting.

For more details circle #386 on mailing card.

Book Announcements

Brownell, "A Textbook of Practical Nursing," 4th Ed., 512 pp., $4.25. "Mayo Clinic Diet Manual," 2nd Ed., 247 pp., $5.50. O'Hara, "Psychology and the Nurse," 4th Ed., 313 pp., $3.50. Routh, "Laboratory Manual of Chemistry," 3rd Ed., 109 pp., $1.75, and "Fundamentals of Inorganic, Organic and Biological Chemistry," 3rd Ed., 418 pp., $4.00. Thompson, "Introduction to Microorganisms," 3rd Ed., 552 pp., $5.25. Villee, "Biology," 2nd Ed., 670 pp., $6.50. **W. B. Saunders Company, W. Washington Square, Philadelphia 5, Pa.**

For more details circle #387 on mailing card.

Suppliers' News

Gilbert Hyde Chick Company, 821 75th Ave., Oakland 21, Calif., manufacturer of hospital orthopedic and fracture equipment, announces removal of its branch office from **16 James St., Elberton, Ga.,** to larger quarters at **788 Ponce de Leon Ave., N.E., Atlanta, Ga.**

Eichenlaubs, 3501 Butler St., Pittsburgh 1, Pa., manufacturer of institutional furniture, announces the opening of a **contract furniture center.** Featuring room and group displays of institutional furniture and furnishings, the new center offers every phase of contract buying under one roof for the convenience of the purchaser.

W. & J. Sloane, 575 Fifth Ave., New York 17, announces the opening of a **Contract Division** under the management of **Harry M. Pearson.** The new division will combine the contract furnishings departments of the four main Sloane stores in New York, Washington, San Francisco and Beverly Hills.

Sperti Faraday, Adrian, Mich., manufacturer of sun lamps and ultra-violet equipment, as well as other scientific and recording material, announces the acquisition of **Cooper Hewitt Electric Company** of Hoboken, N.J. The new company will manufacture all types of tubes and bulbs involving gaseous discharge, as well as mercury vapor tubes.

PRODUCT INFORMATION

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Key

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Key

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USE THIS CARD

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Meinecke Metal Medicine Glass Covers & Markers
Meinecke Colored Medicine Cards
Meinecke Medicine and Syringe Tray Sets

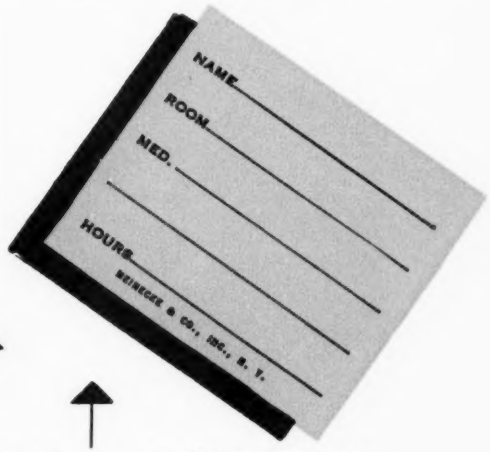
THE MODERN, ERRORLESS

MEDICINE TRAY TECHNIQUE

Errors just don't happen when you use the modern Meinecke Medicine Tray Technique. Meinecke Colored Marking Cards stay firmly in place on Meinecke Combined Medicine Glass Cover and Pill Trays . . . keep you constantly informed of *what* the doctor ordered—and *when* it is to be administered.

Medicine Tray Set

Non-tarnishing, chrome-plated brass rack with matching Boltabilt Tray. 11" x 14" Tray holds 11 one-oz. glasses and pitcher; 8" x 10" tray holds eight one-oz. glasses and pitcher. Tray sets for 12 and 20 glasses without pitcher also available.

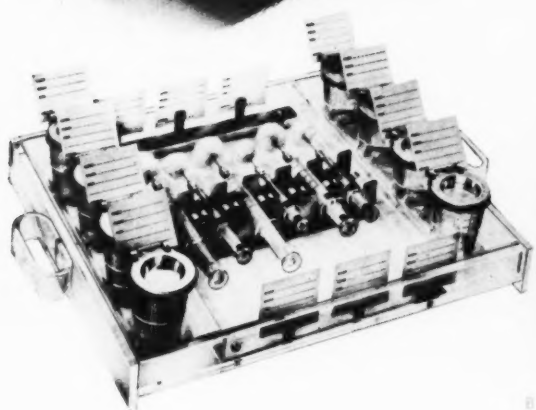


COLORED MEDICINE CARDS

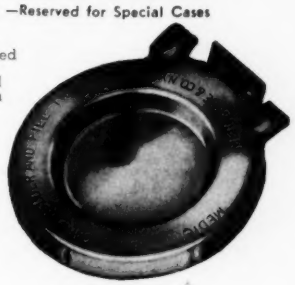
Eleven distinct colors denote the different hours of administration—simplify work and minimize errors. Either plain cards or cards printed as shown available. (Patents 1,020,896; 2,031,892; 2,095,817.)

Eleven Standard Colors:

- Green —Q.A.M.—6 A.M. (every morning)
- White —B.T.—9 P.M. (bedtime)
- Blue —A.C.—7 A.M., 11:30 A.M., 4:30 P.M. (before meals)
- Red —Q.I.D.—8 A.M., 12 noon, 4 P.M., 8 P.M. (four times a day)
- Buff —P.C.—9 A.M., 1 P.M., 6 P.M., (after meals)
- Pink —B.I.D.—10 A.M., 6 P.M. (twice a day)
- Orange —Q. 3 HRS.—(Every three hours)
- Gray —T.I.D.—10 A.M., 2 P.M., 6 P.M.
- Yellow —Q. 2 HRS.—(Every two hours)
- Purple —Round-the-clock medication
- Salmon —Reserved for Special Cases



Card Used in Vertical Position



A

Combined Syringe and Medicine Tray

Noiseless, lightweight Plexiglas Tray measures 16¾" by 12"; provides accommodation for eight standard medicine glasses and six fully-loaded 2 c.c. or 5 c.c. syringes and assures proper identification through use of Meinecke Colored Medicine Cards and Covers—other styles available to hold 12 syringes.

Medicine Glass Cover & Marker

Non-tarnishing, solid brass, heavily chrome-plated.

A. Cover and Pill Tray before Card has been inserted.
B. Card used in vertical position (can also be attached flat).

Write for prices and descriptive literature.

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Index to Products Advertised—*Continued*

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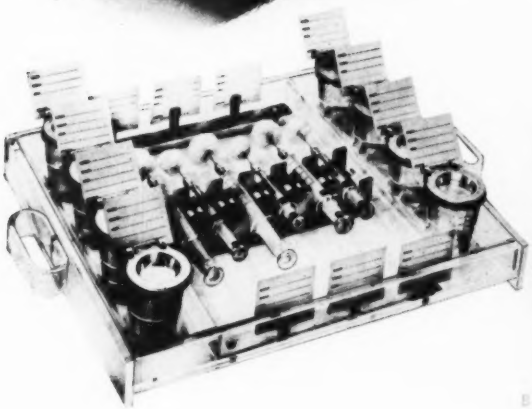

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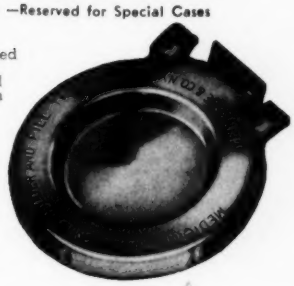

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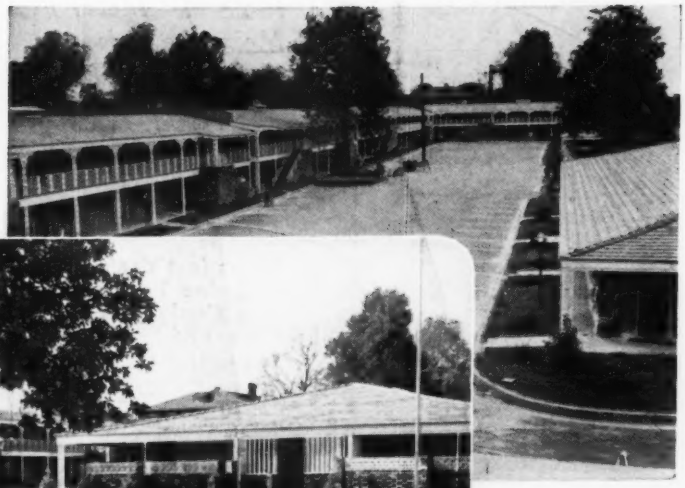
L. L. STROUD
mechanical engineer
construction supervisor

W. A. SOEFKER & SON
plumbing contractor

CENTRAL SUPPLY CO.
plumbing wholesaler

KOHLER CO.
plumbing fixtures

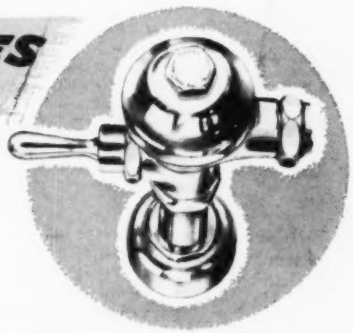


The architectural styling of this new court at the gateway to Memphis, Tenn., is New Orleans French Colonial, with old brick fronting and traditional ornamental iron for support of and railing on a continuous balcony. An alluring swimming pool, faced by patio suites, is set in a beautifully landscaped area. The two bronze doors opening into the commodious lobby were once the ornate entrance to the famous Sherry's Restaurant, New York.

ONLY THE BEST FOR EVERY GUEST

TOWN PARK MOTOR HOTEL, MEMPHIS, situated at the convergence of five east-west U.S. highways and only a few minutes from downtown, is a million-dollar, 150-room luxury court that ranks among the finest in the nation. In the planning, construction and furnishing, two factors were dominant—comfort and enjoyment for guests. The entire structure is served by a most modern air conditioning system, controlled noiselessly. Noise, always disturbing to travelers, is practically non-existent here. Single rooms and suites are separated by thick masonry walls and have acoustical ceilings. Mr. L. L. Stroud, a partner, said: "I cannot over-emphasize the necessity of controlling the noise factor. We use SLOAN *Quiet-Flush* VALVES throughout our motor hotel." Because flush valves by Sloan build good will, create favorable comment and make important savings, doesn't the example of this excelling hotel suggest an idea to *you*, and explain why...

***more* SLOAN *Flush* VALVES**
are sold than all other makes combined



SLOAN VALVE COMPANY • CHICAGO • ILLINOIS

Another achievement in efficiency, endurance and economy is the SLOAN *Act-O-Matic* SHOWER HEAD, which is automatically self-cleaning each time it is used! No clogging. No dripping. Architects specify, and Wholesalers and Master Plumbers recommend the *Act-O-Matic*—the better shower head for better bathing.

Write for completely descriptive folder